Thursday 16 October 2025

(10.04 am)

MS MALHOTRA: Good morning, Chair.

THE CHAIR: Ms Malhotra.

MS MALHOTRA: Today we return to hear evidence from the bereaved families of those who died while under the care of trusts in Essex. This morning we will hear from Paul and his wife, Anna Rucklidge-Smith. They will be giving evidence about Paul's mother and Anna's mother in law, Doris Joyce Smith, who died on 14 October 2020, aged 74.

Their evidence will be followed by Samantha Reains who will be giving evidence about her uncle, Keith Stubbings, who died on 24 April 2019, aged 61.

Then this afternoon we will hear from Sofia Dimoglou. She will be giving evidence about what happened to her mother, Valeriy Dimoglou, known as Val, who died on 9 October 2015 aged 76.

Both sessions will include details of the care and treatment received by those who died and will also include some details of how they died. There may be aspects of today's evidence that are difficult to listen to. Understandably, there may be some for whom it may not be possible to sit through the two sessions. As with the other days, anyone in the Inquiry room should feel free to leave at any time.

May I take this opportunity to remind those engaging with the Inquiry that emotional support is available for all who require it. Present here again today are emotional support staff, Hestia, an experienced provider of emotional support. They are currently in this hearing room and can be identified by their orange coloured scarf. There is a private room downstairs where anyone who needs emotional support can talk to the Hestia support staff. If you prefer, you can speak to a member of the Inquiry team and we will put you in touch with the emotional support staff. We are all wearing, or have with us, purple lanyards.

For those following the hearing online, information about the emotional support that is available can be found on the Lampard Inquiry website at lampardinquiry.org.co.uk. The "Support" tab is near the top right-hand corner. We want everyone engaging in this Inquiry in whatever way to feel safe and supported.

Chair, we are now ready to hear from our first witnesses this morning, Paul and Anna, who would like to be referred to by their first names and for Doris to be referred to by her first name. They would like to affirm and can we please do that now.

ANNA RUCKLIDGE-SMITH (affirmed)

PAUL RUCKLIDGE-SMITH (affirmed)

Examination by MS MALHOTRA

Q. Thank you very much. We heard you, Paul, speak about your mother, Doris, at the commemorative hearings in the afternoon of 23 September 2024. You were accompanied then, as you are now, by your wife Anna. Doris died on 14 October 2020, at the age of 74. The five-year anniversary of her death was therefore just two days ago. Doris died at Broomfield Hospital. Is that right?

A. PAUL: Yes.

A. ANNA: Yes.

Q. She died following a head injury sustained from a fall whilst at the Ruby Ward on 9 October 2020, is that so?

A. PAUL: Yes.

Q. Is your understanding that the Ruby Ward is an older in-patient service for people over the age of 65 living with mental ill health?

A. ANNA: Yes.

Q. Thank you. Did her care fall under the Essex Partnership University NHS Foundation Trust, known as EPUT?

A. ANNA: Yes.

Q. You have both provided a joint witness statement, dated 1 September this year. It is signed by you both. Have you had an opportunity to read it recently?

A. ANNA: Yes.

Q. As far as you are aware, is it accurate and correct?

A. ANNA: Yes.

Q. There are seven topics that I hope to cover with you this morning. The first are hospital attendances in May 2020 and the assessment of Doris's mental health in that period. An example that you would like to speak about of what you term "good practice", I would like to talk about that. And by way of background, Doris's care in the community, family engagement in Doris's care and the falls risk assessment that was undertaken whilst Doris was at the Ruby Ward, including the events of 9 October 2020. I would like to ask you about the use of technology, which you refer to in your statement, the inquest and a prevention of future deaths report that was issued by the Coroner. I would finally like to ask you about recommendations that you invite the Chair to consider, which we may also touch upon during the course of your evidence.

Turning, then, firstly to, by way of background, in your witness statement -- you don't need to go to it, if you don't want to, but for those following your witness statement it is paragraph 4, page 2 -- you describe your first experience of Doris's mental health decline in 2012. Is that right?

A. PAUL: Yes.

A. ANNA: Yes.

Q. And I believe she would have been around 67 years of age at that time, is that correct?

A. PAUL: Yes.

A. ANNA: Yes.

Q. She was referred to EPUT psychiatric services by her general practitioner. She was admitted to the Peter Bruff mental health ward, an acute adult in-patient service in Clacton-on-Sea. Is that your understanding?

A. ANNA: Yes.

A. PAUL: Yes.

Q. In your statement at paragraph 4, page 2. You refer to Landermere as well in the same context. Are they two different units or were they the same, are you able to recall?

A. ANNA: I don't really recall that to be honest it was so long ago.

Q. She was there for around six weeks, is that correct?

A. ANNA: Yes.

Q. And there was a decline in 2016 that you refer to at paragraph 5, page 2, so four years later, where she was taken to Colchester General Hospital following a psychotic episode and discharged three days later, is that correct?

A. ANNA: Yes.

A. PAUL: Yes.

Q. So far as you are aware, are you able to help with why she was discharged?

A. ANNA: So she was quite psychotic when she was in the ward and we went in to visit her, I think, on the second day, and she all of a sudden had come out of this state of psychosis and was very much back to her normal kind of self, and had explained to us that she had had a lot of hallucinations at the time and they were very scary, but she was quite okay then, wasn't she?

A. PAUL: Yes.

A. ANNA: When we spoke to the doctors they had said it could have been a UTI, a urinary tract infection. However, when we asked about the urine sample that was never actually confirmed. It was just, kind of, I think maybe a working diagnosis that that's what they thought had happened. We didn't really get any more sort of information about that admission and shortly after she went home and she was back to her normal kind of routine and life.

Q. Okay, and so far as you are aware, was there an assessment of her mental health at that stage or was it the medical condition suspected, urinary tract infection, that was investigated?

A. ANNA: Yes, it was the physical health side of things that were looked at, I don't believe there was any mental

health assessment at that time.

Q. Then again, four years later, in April 2020, at paragraph 6, page 3 of your statement, you describe a significant decline in 2020. Were there any early signs that you became aware of?

A. PAUL: Yes, so the early signs were always actually physical. She would start to lose her balance, the way she spoke changed, didn't it?

A. ANNA: Yes.

A. PAUL: And that was always the warning sign that something wasn't right and we were noticing that in sort of early spring 2020.

A. ANNA: We tried to address it with her, to sort of say that we had concerns, but she said she was fine, and we tried to push but that was kind of as far as we got.

Q. So this was you say in Spring of 2020?

A. ANNA: Mm hmm.

Q. Can you remember when you first observed it in 2020?

A. ANNA: It probably would have been.

A. PAUL: Late March.

A. ANNA: Yes, I would have said March time because then she had the fall and fractured her arm in April, so a little bit before that, probably a month or so.

Q. Can you to the best of your recollection help us with how many times that happened?

A. ANNA: How many times what happened?

Q. That she had those warning signs of losing her balance for example?

A. ANNA: On each sort of time when you saw her mental health starting to decline, they were the types of symptoms she would show before then the mental health side of things started to sort of decline.

Q. Did it always happen or was it just sometimes?

A. ANNA: I would say every time that we noticed it her mental health was on the decline.

Q. In your statement at paragraph 9, page 3, for those following, you give four occasions when Doris was taken to hospital in May 2020?

A. ANNA: Mm hmm.

Q. I am going to summarise those. The first was 5 May, and you refer to that at paragraph 9(a), page 3. Then the second occasion was on 7 May, which you deal with at paragraph 9(b) on page 4. Then 22 May, which you talk about at paragraph 9(e) on page 5. Then the fourth occasion on 23 May at paragraph 9(f), page 5. In all of those occasions was she always taken to Colchester General Hospital?

A. ANNA: Yes, I believe so.

A. PAUL: Yes.

Q. Can you help us with whether she was taken to hospital on

those four occasions because of her mental health or were there other reasons?

A. ANNA: So I believe on the first admission, on 5 May, she was dizzy, she was struggling to stand and her speech was slurred. She was -- I believe at that time, she was admitted to a medical ward and she was very aggressive at that time. We started to get calls, and this was out of character for her, we were very close with Doris, we spent a lot of time with her. At that point that is when she starts to become -- her character started changing. She became aggressive to us and didn't really want us involved in her care.

Q. And so that brings me on to my next question. You say that she didn't want you involved in her care. That must have been very difficult for you.

A. ANNA: Mm hmm.

Q. Were you present on those four occasions?

A. PAUL: No.

A. ANNA: No, this was the point. So the whole way through this we struggled to be involved because she was very aggressive and had decided she really didn't like Paul and I anymore, which was, as I said, very out of character for her and this is how we knew this wasn't her normal being. It was very difficult. We couldn't go down there because she would shout at us down the phone.

She would ring us at 2 or 3 o'clock in the morning when she was at home and be abusive to us. So it was very difficult to be involved when the mental health services were thinking everything was okay, and we were trying to explain, "Actually this isn't what she's usually like." They didn't think she had issues with capacity, so therefore, they were telling us they can't tell us things because they deemed her to have capacity. So it was a really frustrating time for us ultimately.

Q. We are focusing on May 2020.

A. ANNA: Yes.

Q. Were you her next of kin?

A. PAUL: Yes, I was, yes.

Q. Were you contacted by the hospital at all?

A. PAUL: Didn't we have to ring?

A. ANNA: So I believe in that first initial admission on 5 to 7 May, we did have some contact from a mental health liaison team and I believe the home treatment team. I remember speaking to them at length about our concerns about her mental health. They wanted, I think she went home on 7 May, and we had told them how concerned we were about her going home, because we felt that she needed a lot of support for her to be safe in the community. But they were like, "Well she's going to go home", and we kept saying to them we were concerned about it. Hence

she went home on 7 May, she was then wandering and aggressive in the little mews where she lived after being discharged. An ambulance was called, I believe she then went back into hospital, had a seizure, and then she was admitted again until 16 May. Again, I believe we spoke with the discharge team and the home treatment team for -- and before that discharge on 16 May, but again she didn't really want us involved in her care. She was continuing to be aggressive to us, calling us.

Q. So you can recall one occasion where you were contacted and there was a conversation?

A. **ANNA:** Mm hmm.

Q. Can you help us, please, with why you felt the need to speak to the home treatment team that had contacted you? Why was it important for you to speak to them?

A. **ANNA:** I think because of the way she was, she was still being very aggressive to us, so we knew that was very out of character for her. There was a reason for her to be like that, but we hadn't done anything per se. So it was, sort of, to us that was clear warning signs that there was something amiss with her mental health and her mental health was on the decline. Because she didn't want us involved in her care, it then made it difficult for us to try and support her when she was going to be discharged. So I was trying to explain to the mental

health teams and the home treatment team, the discharge team, that actually if she is going to be discharged she doesn't want anything to do us and she doesn't have anyone else. What support was going to be in place? Even with just things like shopping and making sure she had that support in the community, when she was being discharged, if she wouldn't let us be involved in her care.

Q. Just so we are following the chronology here, you mentioned earlier about the decline in 2016.

A. ANNA: Mm hmm.

Q. We've touched upon, you mentioned the fracture to the wrist and that was on 22 April 2020 and then these four occasions of admissions in May 2020. As far as you were aware, then, there was one conversation, as far as you can recall, with the home treatment team and the mental health team. Were there any other occasions that you were spoken to that you can recall?

A. ANNA: I think on 21 May -- she was discharged home on the 16th. 21 May she again was very aggressive, and we were having reports from the neighbours and the family. So one of Doris's --

A. PAUL: Great niece.

A. ANNA: Yes, her great niece lived next door to her, so she would report things back to us, so we would know how

she was doing. She had called with concerns about Doris, and on 21 May, I believe there were two ambulances called, both times they were really concerned on the phone to us, but they said they couldn't take her into the hospital. But the home treatment team -- they were going to send information to home treatment team and ask them to visit the next day, and I believe probably that morning, on the 22nd, I remember ringing the home treatment team just to say, "This is the situation, we are very concerned, are you going to visit today?" Which they did.

Q. Let's just break that down slightly, then. So turning to 5 May at paragraph 9(a)(i) of your statement, page 4, she was referred to the mental health liaison team and then later to the older adult home treatment team?

A. ANNA: Yes.

Q. Are you aware of -- is that the first occasion when you had a conversation with them?

A. ANNA: Yes.

Q. Does that help you in terms of timings?

A. ANNA: Yes, that would have been the first time.

Q. Then at paragraph 9(b)(ii) you make reference to Doris's discharge and that you spent a lot of time talking to the home treatment team?

A. ANNA: Yes.

Q. And the ACE team. I just wonder can you explain what the ACE team was?

A. ANNA: I don't remember if I'm honest.

Q. And so that was part of that same conversation that you were having with them, and the information that you were providing in terms of her historical background.

A. ANNA: Yes.

Q. Then on 22 May, which is her third admission, at paragraph 9(e) on page 5, she was referred to the mental health team on that occasion for an assessment.

A. ANNA: Yes.

Q. As far as you are aware, did that assessment take place? Were you involved at all, can you remember?

A. ANNA: So she was taken in I think it was the evening, if I remember, I believe that was a Friday, she was taken in. They kept her in A&E overnight, and then on 23 May we received a call from the approved mental health practitioner, who I would say was actually very good, and I would like to highlight that as well, that she was very good at her job, and she really took on board our concerns and really, for the first time in this whole mess, it was the first time that we felt we were actually listened to.

A. PAUL: Yes.

Q. I am going to come back to that in a moment, but just

going back to the 23rd, we had the third admission on the 22nd, Doris was discharged, you say, to the psychiatric team on 23 May at 1.55 in the afternoon, but then went back to hospital the very same day on the 23rd; is that right?

A. ANNA: No. So the 22nd she was in A&E, they did the assessment on the 23rd, and then she was kept under -- she was sectioned under section 2 and that's when she was transferred to Henneage Ward.

Q. So you have spoken about this assessment on the 23rd, when Doris was assessed by an advanced mental health practitioner, and in your statement you refer to two psychiatrists as well; is that right?

A. ANNA: Yes.

Q. Were you present for that assessment?

A. ANNA: No, we weren't, this was all during COVID, so there was no way to be present. They just were ringing, so she rang to have a conversation with the family before they went to do the assessment, because they wanted some background before then carrying out a proper mental health assessment. Obviously, if we had been allowed to attend, absolutely we would have, but yes, COVID, there was none of that at that time.

Q. And so you were rung on the first occasion before an assessment was undertaken?

A. ANNA: Yes.

Q. With Doris, and is there anything that you want to say about having been spoken to before an assessment took place?

A. ANNA: I think that was, yeah, it was a very good thing to do, and I think that's something that definitely should be done because obviously some people with mental health concerns, they are going to say things that they think someone might want to hear. They are not going to say exactly how they are feeling or what actually has been going on, and by speaking us to us I think the approved mental health practitioner got an understanding of what had been going on in the past month and, you know, how over since, sort of March time, her mental health had declined. It was good to put in context of what her normal routine and things were and how this was not what was happening at the moment.

Q. You mentioned earlier that there was a time where Doris didn't want you involved because she was unwell. Can you, at this stage, can you help us with whether that was still the case, that she didn't want you involved in her care, but you were still contacted notwithstanding that? Can you just help us understand the context?

A. ANNA: Yes, I mean, she still was very angry with us, didn't like us, but the hospital obviously felt that they

needed some context and they did contact us.

Q. You mentioned the earlier assessments you were present at, but if you were to try and draw any parallels between the two assessments, the one on the 23rd, where you were contacted, and the earlier ones in May, what would you say the differences, from your perspective, were of those mental health assessments?

A. ANNA: That we were actually listened to and our concerns were taken on board.

Q. And what about the outcome? So on this occasion on the 23rd you mentioned that Doris was sectioned?

A. ANNA: Mm hmm.

Q. On the other occasions what was the outcome?

A. ANNA: So the outcome was, sort of, input from the home treatment team, which would be that they were going to provide support at home. I just don't think the level of support that was provided was adequate for how unwell she was at that time.

Q. So you told us that Doris was detained under the Mental Health Act on the Henneage Ward until 15 June 2020; is that right?

A. ANNA: Yes, it is, yes.

Q. You describe in your statement at paragraph 10, page 6, that her care there was substandard. Why do you say that?

A. ANNA: So she had undergone a scan that showed some small vessel ischaemia. We kind of queried what that was and we were just told, "Oh it's nothing, it's just a normal part of ageing", and they used kind of this diagnosis, delirium, which they were saying had stemmed from the right wrist injury, and we just didn't believe that was what was going on, and we tried to raise our concerns. But again, it just fell on deaf ears and no one would listen to what we were trying to say.

Q. Just for context here, you say that it fell on deaf ears, what information were you able to provide that a medical practitioner who was meeting her for the first time might not have known?

A. ANNA: So I just think they kept saying, "Her behaviour is very normal." We just kept trying to explain to them that this wasn't normal for her. They might be seeing this as normal behaviour, but I really felt the need for them to take on what was her normal. I don't believe, when you meet someone for the first time that you can say that that is their normal behaviour for that person. If you don't know someone, I don't really think you can make that judgment.

Q. Now, just taking things slightly out of turn, I want to just draw upon what you have said there and turn to the recommendations that you invite the Chair to make and to

consider. This is at page 33 and I am going to ask if that can be displayed on the screen, please. It is page 33 of your statement, paragraph 128. We can see there "Recommendations for change", 128, subsection (a), "Consideration of family's views". Can you tell us, please, why is it that you invite the Chair to consider this as a potential recommendation?

A. ANNA: I just, I just really feel that it's so important. We just kept being told, "Oh well, it's" -- I don't really know the best way to explain it. I just feel it's a crucial part of our whole assessment. It's not just about that -- well, of course it's all about that person, but that person can say anything to anyone.

A. PAUL: Yeah.

A. ANNA: And say things you want to hear. Families know, like the ones closest to me know me the best and they can tell when something's amiss. When you are in a state when your mental health is declining you are not always going to be aware that things are declining and actually the ones closest to you are the ones that are going to be able to highlight that, so by taking into consideration the family's views maybe there would be different treatments and hopefully different outcomes for patients.

Q. One of the further recommendations on that same page, at page 33 subsection (b) that you invite the Chair to

consider is a "Patient-centred service". Does it flow from what you have just said there about looking at the patient different treatment options, is that why you invite that second recommendation? Do you want to say anything further about that?

A. ANNA: I think ultimately, yes, patient-centred care you need to be looking at that person as an individual and what might work for one person is not necessarily going to work for someone else. So I think it is taking into consideration all factors before looking at best case scenario for that individual.

THE CHAIR: And your comments about seeking families' views play into that?

A. ANNA: Yes, absolutely, yes.

MS MALHOTRA: Thank you. We can take that down from the screen now, thank you very much. Going back, then, to the discharge on 15 June of 2020, you explain in your statement, we were talking about the Henneage Ward and we are on page 6, bottom of page 6, paragraph 14, you say that Doris was under the care or was discharged to the Home Treatment Team. You say that at page 7, the top of page 7, paragraph 15. What was your understanding of the Home Treatment Team and to put this into its proper context, Doris had already been under the care of the Home Treatment Team after her discharges in May of 2020;

is that correct?

A. ANNA: Yes.

Q. So this is your second set of experience with the Home Treatment Team. Just explain to us what your expectations were?

A. ANNA: I was expecting that, we thought they were going to be going in regularly, checking she was okay, was she taking her medications, was she looking after herself, was she, you know, personal care, cooking, cleaning, was she coping at home. That was my understanding, that they would be sort of checking up on her regularly, making sure she was safe to be at home.

Q. And she had a care co-ordinator; is that right?

A. ANNA: She did.

Q. I want to ask you then about those instances of care and focus on the hospital admissions that arose from it. So in terms of time, we are in July of 2020?

A. ANNA: Yes.

Q. There was an incident on 3 August of 2020, on the bottom of page 7, paragraph 17, where you say at this stage Doris's balance had worsened, her mental health was deteriorating and she had fallen against a neighbour's car, damaging it.

A. ANNA: Mm hmm.

Q. So again, off balance and being wobbly, as you describe

it in the statement. I want to then move on in time to 8 August, which on page 9, bottom of page 9, paragraph 28, there was a visit by the care co-ordinator who had been visiting during this period of time?

A. ANNA: Mm hmm.

Q. But on this occasion there was an instance when a security officer was involved with Doris. Could you tell us about that incident?

A. ANNA: So we received a call from a security officer at Morrisons to say that Doris had been caught shoplifting, which is like unbelievably out of character for her. This is a woman that when Paul was a child walked out with some loo rolls on her trolley accidentally and went back in to pay for them when she realised. She was a very, very honest woman, she would never do that. So we had this phone call from a security officer at Morrisons, again at this time Doris wasn't really speaking with us, didn't want us involved. Also she lived in Clacton, we live in Thurrock, it was quite a way. So we spoke to the security officer and explained that she had shoplifted and that a couple of days prior to that she had also been caught shoplifting and she was going to be banned from the shop. She could see that Doris was very unwell and was very concerned for her so --

Q. Can I just ask you to pause there, you are speaking quite

fast and I am conscious that we have got somebody who is transcribing. You haven't done anything wrong at all, but I just wonder whether we could slow down slightly. I am trying to take a note as well and I can't write that quickly. So there was an incident at Morrisons, she had been there the day before.

A. ANNA: Yes, I think a couple of days prior, yes.

Q. And this was now an occasion where the security guard had got involved?

A. ANNA: Mm hmm.

Q. What were you told about that incident?

A. PAUL: She tried to walk out with the whole trolley of shopping so she had done her weekly shopping and then just walked out the door with it.

A. ANNA: And extra things. Apparently, she had said she was trying to get things for nurses in the NHS because they needed to be given things for how well they were doing in COVID, you know, it was those kinds of things.

Q. And as a result of the security guard intervening how did they get involved with Doris, how did they manage that situation?

A. PAUL: We actually saw body cam footage, didn't we, from the two security guards.

A. ANNA: It was absolutely heart breaking.

A. PAUL: Where they were stopping her, yeah.

A. ANNA: So they stopped her. The lady -- there was a woman security officer and she had realised she was like, "something's not right here", hence she had managed to get our number from Doris's phone to ring us and she said to us, "Where are you?" We explained that we lived quite a way away. She said, "Would it be okay if I took her home to make sure she's okay?" We of course said "Yes, that's absolutely fine."

Q. So they actually took her home?

A. ANNA: They took her home.

Q. And did they speak to you and confirm that she had got home, what did they tell you?

A. ANNA: So they had gone into the house and there was blood everywhere and it was sort of very untidy. Again, this is really out of her character. Doris's house was, like, you could eat your dinner off the floor when she was well. I had never ever seen such a clean house in all my life. And it was very untidy, wasn't it, there was blood everywhere so the security officer decided that something wasn't right and so she called the police and she called the ambulance service.

THE CHAIR: So she is to be congratulated?

A. ANNA: Yes, she was great, she was brilliant.

MS MALHOTRA: Just wanting sort of your understanding then that the care co-ordinator had been visiting Doris during

this period, July and August, as you detail in your statement, yet we have got to a situation here, by 8 August, where a security guard attends her home and is so concerned that they call an ambulance for her to go to hospital.

A. ANNA: Yes.

Q. All right. Do you have anything that you want to say with regards to that, and sort of the observations that were being kept on her during that July and early August period?

A. ANNA: I would say that, again with the care co-ordinator, I used to ring regularly because we had concerns about Doris. Again, the care co-ordinator I almost -- when I rang I could almost hear her eyes rolling because I could just tell in how she was that she was like, "Oh no not her again", because I did call all the time because I wanted to prevent deterioration in her mental health and she just didn't listen. I find it the most frustrating thing. I do lay a lot of blame on her because I just think if she had listened to us and taken on board what we had said would she have not been admitted and then ultimately not had that fatal fall and died?

Q. Are you all right to carry on?

A. ANNA: I'm fine. It really, really makes me angry. It's

all I want is people to listen to families. I feel it's so, so important.

Q. Would you like to take a break?

A. ANNA: No, I'm fine.

Q. You say that -- back to this incident in August, she went to CGH A&E, I am assuming that's Colchester?

A. ANNA: General Hospital.

Q. General Hospital, and did you, as a result of that incident and the interactions that you had had with the security guard, do anything? Did you make contact with the hospital?

A. ANNA: Yeah, again we called the A&E because we were concerned that the same thing would happen that happened last -- that they wouldn't sort of take on board what we were saying. I got told that they did, they -- I was told that she wouldn't, I was like, "Please don't discharge her without properly assessing", and they assured me that wouldn't happen but guess what, they did.

A. PAUL: I think is that ... she was taken home really late?

A. ANNA: Yes, she was taken home really, really late.

A. PAUL: That's the evening we find out that she was taken home by hospital transport very late, maybe 11, midnight, in a hospital gown and left on her doorstep.

A. ANNA: Then they promised that if anything would happen

that they would contact us, and again they didn't. We didn't even know she was home until one of the neighbours rang to say, "Do you know your mum's home?" And we were like "No, what?" So we then visited her the next day even though she was really still quite angry with us.

Q. So when you visited her the next day what did you observe about her and her condition?

A. ANNA: It was you took -- so we actually went with a couple of friends because we didn't want to upset her too much. So what we did was our friend Sue came with us because she liked Sue, and Sue went in to see her and then Paul came up.

A. PAUL: We waited outside.

A. ANNA: You went in and she -- yeah, you are probably better because I stayed away trying to -- we didn't want both of us to be there to upset her.

A. PAUL: Well, we just walked into her house of chaos, she hadn't eaten properly. There was rotting rubbish in the hallway.

A. ANNA: There were maggots on the floor. She was ravenous, we ended up --

A. PAUL: And this is the house that the care co-ordinator has just recently visited and said, "Everything looks fine."

A. ANNA: She was absolutely starving, so she really wanted

a filet of fish from McDonalds so we went and got it for her, and it was like watching someone who hadn't eaten for a week. She literally was absolutely ravenous.

Q. I want to turn then to events on 13 August, you talk about this at page 11, paragraph 39 of your statement. You say there that there was a plan for Doris to be referred to the Home Treatment Team and that she was referred to crisis support. Is that correct? Did that happen, do you know?

A. ANNA: Yes, as far as we are aware, yes, that did happen.

Q. And then at the bottom of page 11 you talk about six days later, on 21 August 2020, an incident where Doris was running around the mews, banging on doors and shouting that she needed her medication. You describe over the page on page 12 that she was hysterical and was taken to hospital at that time. So this was on the 21st and just to help you in terms of the timing and the chronology then, at paragraph 42 you say that there was a Mental Health Act assessment and she was detained under section 2 at the Ruby Ward on 22 August 2020; is that correct?

A. ANNA: Yes.

Q. And whilst she was there, she was assessed by two psychiatrists and an advanced mental health practitioner; is that correct?

A. Yes, it was the same.

Q. The same?

A. **ANNA:** The same one and I remember her words she said, "What have they not been doing in the community for her to be back here?"

Q. And this was the time where you became aware of her diagnosis. Was this the first time that you became aware she had a formal diagnosis?

A. **ANNA:** Yeah, I mean, I think the first diagnosis was, yeah, high anxiety, depression with psychotic features. I think that then changed later down the line, because in the first admission it was that it was all due to -- it was delirium due to the fractured wrist. That's what they had put it down to that whole -- for the first admission.

Q. And so Doris stayed at the Ruby Ward. I want to move on to our next topic about the falls and falls risk assessments. Given the background that you have described, that you have both described, of Doris being wobbly, losing her balance, neighbours reporting that she had been -- that she had fallen and then there being your observation that there was a decline in her mental health, when she attended the Ruby Ward was there a falls risk assessment as far as you were aware?

A. **ANNA:** Well, now -- I didn't know at the time, I would have just thought it would have been done with her

vulnerability and how at risk she was of falling. However, what we then have realised is that actually the falls risk assessment wasn't done until 2 September.

Q. And just in terms of helping you, I appreciate this was some time ago, there was a serious incident report, was there?

A. ANNA: Yes.

Q. And there was a root cause analysis report; is that right?

A. ANNA: Yes, there was.

Q. And there was also an inquest; is that correct?

A. ANNA: Yes, that is correct.

Q. And I mentioned at the outset a prevention of future deaths report as well that was issued by the Coroner?

A. ANNA: Mm hmm.

Q. I wonder if it helps you in terms of framing where we are and remembering the details, if I could invite page 20 of your statement, please, to be put up on the screen. It may help us orientate where we are. So paragraph 83, page 20, for those following. This here are specific recommendations that were made by a physiotherapist and I am going to read out, these were recommendations that were made by a nursing staff. So to orientate us in time, Doris attended, as we know, at the Ruby Ward on the 22nd, the 22nd was the assessment, and then 23rd there

was also then no risk assessment. It was on 2 September that that risk assessment took place. And there were a number of instances where she had had unwitnessed falls; is that right?

A. ANNA: Yes, there were.

Q. And I think, if we can break down the falls in this way. 1 October, there was a fall and on that occasion it was an unwitnessed fall whilst she was on the Ruby Ward; is that right?

A. ANNA: Yes.

Q. And there was a palpable mass on her head and she was vomiting; is that right?

A. ANNA: As far as I'm aware, yes.

Q. I am just going to ask that that does stay up on the screen for the moment but just to help you, we are at paragraph 70 of page 17 of your statement. It says here in your statement that she was:

"A high-risk-of-falls patient, she was elderly, frail and had been losing weight due to lack of food and fluid intake."

Obviously she was in hospital at this time, so can you just help us little bit about what was going on in terms of her weight management and how her nutrition was at that time?

A. ANNA: So she was so unwell, she wasn't eating and she

wasn't drinking and again, like, Doris was a very, very petite lady.

THE CHAIR: A very?

A. ANNA: Petite lady, very, very, she was small and petite, but boy did she have an appetite. She could eat more than I could, and during her stay she just wasn't interested in food. Although this was kind of COVID times, in the end they started to let us come to visit. We went to visit her on the ward a couple of times. And we did take different foods that they thought she might like, things high calories to try and encourage her to eat, didn't we?

A. PAUL: Yes.

A. ANNA: A couple of times we even got like McDonalds delivered to the ward to try to encourage her to eat, but she really -- I think she was so mentally unwell she just didn't want to eat. She was also, I remember she had been prescribed a nutritional sort of like Calogen, which is like shots of nutritional --

Q. Supplements.

A. ANNA: Yeah, exactly.

Q. So she had been prescribed those?

A. ANNA: Yes.

Q. Notwithstanding that, you describe she was losing weight and she was frail at that time?

A. ANNA: Yes.

Q. So there was the fall on 1 October and you describe the circumstances of that, she was taken to the accident and emergency department, where a CT scan was performed. Then if we go to 8 October, which you describe at paragraph 77, page 18 of your statement, there was another unwitnessed fall on this occasion when she was walking to the bathroom. This time she hit her head, hurting her back. That was the second unwitnessed fall that she had suffered in the space of eight days; is that right?

A. ANNA: Yes.

Q. On this occasion, you say at paragraph 78, she wasn't taken, as far as you were aware, she wasn't taken to the accident and emergency department for a CT scan. And you talk here at paragraph 78 about level 2 observations and observations, appreciating it was some time ago, are you able to help us with what your understanding was about when she was to be observed at that time?

A. ANNA: So I can't remember the levels of observations because it was so long ago, but my understanding is that around policy following a head injury is that the person needs to have 24 hour neuro-observations after the fall, which weren't followed here, and also I believe the policy also states that they should have had a CT scan

and on the 8th there was a palpable lump, yet she wasn't taken for a CT scan.

Q. I think on this occasion, the 8th, she hit her head and back and there was a 2 cm lump on her head.

A. ANNA: Yes.

Q. And then you mention in this paragraph about AT, assistive technology, I think. Can you explain to us what your understanding of the use of technology in Doris's care was around this time in October of 2020?

A. ANNA: So we had been advised that because she was at high risk of falls and because of the falling, that she would have been put in this room that was assistive technology, and our understanding was that it would alert staff if she got up from her chair. So if she was in the room on her own and she got up, there would be some kind of alarm would go off, and then they would go to ensure that she was safe when she was mobilising, and we also thought that that would be on all of the time. However, I don't believe that was the case.

Q. Okay. We will come back to the assisted --

THE CHAIR: Sorry, can I just ask about that? You were told -- so did you have a sort of formal conversation about that and whether you consented to that?

A. ANNA: Yes, it was one of the nurses had called and we were just discussing around falls. I think we had

ordered some new -- we were trying to just find any way to reduce the risk. We had ordered some new slippers and then they had mentioned about this assistive technology and did we think this was a good idea, and we were, yeah, all for this, anything we can do to prevent her falling, absolutely.

THE CHAIR: Can you recall whether you were told in specific terms that if the alarm went off, someone would come?

A. ANNA: Yes, that's what we were told, yes, absolutely.

THE CHAIR: Thank you.

MS MALHOTRA: Can we please have up on the screen your recommendations, because you make, this is at page 34 of your statement, paragraph 128(c). You invite the Chair to consider assistive technology as one of your recommendations, and what you say here is that so far as you understood it to be, the assistive technology had not been turned on on 8 October and after Doris's second unwitnessed fall. Do you want to talk through the recommendations that you invite the Chair there to make?

A. ANNA: I think it's ... it's really that we would like to promote widespread use in all older adult frailty units in the UK, where falls risks to patients are usually very high; urge wards to ensure any decisions regarding assistive technology are communicated to all relevant staff at pivotal times throughout the day, such as

handover and safety briefings and huddles; implore with wards that where AT is an option it must be fully functional and when repairs need to be made they must be done. And then high risk patients must be moved to rooms where the AT is functioning. I just think it is a really important part if you can prevent any falls. That's quite an easy way, without having someone sitting with someone 24 hours a day, of doing it. Yeah, and that people respond to the alert ultimately, because there's no point having it and then not listening to when the alarms go off.

Q. Just help us then, you mentioned earlier the assistive technology, so far as you understood it, was on Doris's chair so that would have been a trigger if she had fallen then.

A. ANNA: Yes.

Q. Was it used any more widely in her room, do you know at all?

A. ANNA: I believe there are pressure mats by the bed, yeah.

A. PAUL: On the bed as well, yeah.

A. ANNA: So that if she got up it was either, I believe it's when you swing your legs around to get out of bed that there was a pressure mat there that would have then gone off.

Q. And so we go back, I am going to ask you then about the 8th that we've talked about, the fall on the 8th. Did you have a conversation with the Ruby Ward about that fall?

A. **ANNA:** Yes, I believe that the ward manager had called us to say that she had hit her head. It was, I believe that was the morning of the 9th we were called to say it had happened the previous day but there had not been any need for her to go to the general hospital, and at that point that's when we realised that she was -- that the assistive technology hadn't been used and that they were about to turn it on.

Q. And she was seen on the 9th by a physio, a physiotherapist, and so going back, then, to page 20, if we could have that back up, page 20, paragraph 83, thank you. We can see there some recommendations that were made for the nursing staff. So:

"'(a) To continue to use assisted Technology in Doris's room ...

(b) To encourage Doris to elevate both lower limbs on a footstool'", and to elevate her foot when she is in a lying position.

(c), relating to her limbs again, and then (d) for a helmet, orthotics, for a helmet to minimise the head injury due to falls risk. And then:

"'(e) For all transfers and indoor mobility - Nursing staff to encourage Doris to transfer and mobilise safely with aid of a wheeled zimmer frame with close supervision of one staff."

And then:

"'(f) For outdoor mobility - Nursing staff to mobilise Doris outdoors in wheelchair.'"

You say here that on the 9th Doris suffered a fatal fall. Can you explain whether any of these recommendations, to the best of your knowledge, were implemented?

A. ANNA: Well, I would imagine not because if she had got up because she had up from her chair and walked, the assisted technology alarm should have gone off so someone should have been alerted.

A. PAUL: Wasn't she found by another patient?

A. ANNA: Yes, also she was supposed to have close supervision of one staff to mobilise, that also hadn't happened. So two things to try and prevent the falls hadn't happened.

Q. And if we then turn, I am sorry to jump about your witness statement, but if we can turn to, before we come to the prevention of future deaths, page 26 of your statement, paragraph 109. You explain the section of the conclusion of the Coroner that Doris sustained a fatal

fall, I am paraphrasing here, but it goes on to say at page 27, over the page:

"The falls risk assessment was only completed 12 days after Doris' admission on to Ruby Ward. Under policy guidelines and procedures, it should have been completed within 24 hours after admission by a nurse. It was finally completed by a senior healthcare assistant instead but had an incomplete medical history.

Subsequent errors and omissions with regard to the updates of the falls risk assessment. No evidence of the physiotherapists advice of close monitoring during mobilising being implemented by staff. Confusion regarding observation levels e.g. 1, 2 or 3, and inadequate frequency of both neurological and ward observations."

Then a lengthy section 4. I am just going pick out and draw out some of those aspects on this page at 27, where it is recorded:

"Had Doris been observed and monitored as she should have been" -- this is under section 4 -- "the fall on 9 October 2020 would either have been avoided or there would have been a staff member present to break her fall. Had the fall been broken, it is likely that Doris would have avoided injury or her injuries would have been less severe. The fall suffered by Doris caused her to suffer

that fatal head injury, a traumatic subarachnoid haemorrhage, which led to her death on 14 October."

The report then goes on to make other observations about evidence that was heard and inconsistencies between staff on the Ruby Ward as to which were the correct levels of observations, and all of these factors led to the incorrect observation of Doris, which contributed to the circumstances leading to her death.

So I just wonder, then if you -- did you attend the inquest?

A. ANNA: Yes, we did.

A. PAUL: Yes.

Q. Was there anything that arose from that inquest that you wanted to make reference to, that I haven't drawn out from this report?

A. PAUL: Yes, so there's a reference -- is it in this evidence somewhere, that they were short staffed, but in the inquest we were told the opposite, because the ward next to the ward my mum was in was closed due to COVID, and we were told in the inquest that they were actually overstaffed on this ward. So that's one of the important parts.

A. ANNA: I think one of the statement from one of the staff mentions that they were worried about having sort of

one-to-one with Doris, with her mobilising, because of staff numbers. Then we thought, "Okay, that's quite feasible because they probably don't have enough staff to do that." However, when we were at the inquest one of the staff was, "Oh no, we weren't short of staff."

A. PAUL: That was one of the questions from the Coroner to the ward manager and that was her answer.

A. ANNA: We had surplus of staff because the other ward was closed so we had two ward staff in one ward.

Q. I mentioned that a prevention of future deaths report was made and published on the Courts & Tribunals Judiciary website on 7 March 2023, this is at paragraph 111, page 28. If we could just have that displayed, please, page 28, paragraph 111. It sets out there what that prevention of future deaths report refers to.

I wonder, I am not going to ask you anything further about that, but is there anything that you wanted to say about the prevention of future deaths report?

A. ANNA: No.

A. PAUL: No.

Q. I would like to ask you, then, about the -- there was a serious incident report and a root cause analysis report. And at page 30 of your statement, if we could have that up on screen, please, at paragraph 121, you list the first recommendation from that report and then over the

page, at page 31, Recommendation 2, Recommendation 3 and Recommendation 4. What was your observation of that root cause analysis report? Was it a report, for example, that you welcomed?

A. ANNA: To be honest, no.

Q. Was there a reason why?

A. ANNA: I just, anything the trust do it's just a paperwork tick boxing exercise, you know. It's just, "Oh we need to be shown to make changes", but do these changes actually happen? I don't believe they do. So doing a root cause analysis and a serious investigation, is that really going to make any changes? It doesn't appear to have so what's the point in it?

Q. And why do you say that it doesn't appear to have made any changes? What makes you say that?

A. ANNA: Because failings continue to happen.

Q. I would like to turn to page 34, if we could have that up on screen, page 34 of your statement and it's at paragraph 128(d). You have there as one of your final recommendations, the investigation report follow up. You say there that:

"We concur with the root cause analysis investigator about the report and its findings and the investigation ... but there should also be deadlines put in place in ALL cases for those targeted to complete and

to respond to an investigator's recommendations. This will ensure those responsible are learning lessons and making changes accordingly."

Is there anything else that you want to add to that?

A. ANNA: I don't think so.

MS MALHOTRA: Those are all the questions that I have for you, Paul and Anna. Can I just check, Chair, do you have any questions?

THE CHAIR: I don't have any more, thank you.

MS MALHOTRA: In those circumstances I am going to thank you very much. We now have a photograph that you have picked that you would like to show of Doris and I am just going to ask if we can have that displayed now, please.

Thank you very much. Now we are going to have a ten minute break now to see if there are any other additional questions for you. But in the event that there aren't any, I am going to thank you very much now for providing your witness statement. We do recognise that it is difficult to relive and to repeat instances, so thank you for providing your witness statement, for coming and giving your evidence today. I appreciate it will have been difficult for you both, so can I thank you very much for doing that and if there aren't any questions, that will be the end of your evidence and you

are free to leave.

THE CHAIR: I would like to add my thanks, very much indeed. It is extremely important for us.

MS MALHOTRA: Chair, we will take a ten minute break.

(11.13 am)

(Break)

(11.30 am)

MS LLOYD-OWEN: Good morning, Chair. We will now hear evidence from Samantha Reains in relation to her uncle, Keith Stubbings. Please can the witness be sworn.

SAMANTHA REAINS (affirmed)

Examination by MS LLOYD-OWEN

Q. Please can you state your full name for the record?

A. Samantha Reains.

Q. You are the niece of Keith Stubbings --

A. Correct.

Q. -- who died on 24 April 2019 at the age of 61?

A. Correct.

Q. You would like me to refer to you throughout your evidence as Sam; is that right?

A. Yes, that's fine.

Q. And your uncle as Keith; is that right?

A. Yes.

Q. And is it right that you are supported today by your husband, Harry, who sits next to you?

A. Yes.

Q. By way of background, the Inquiry sent a request for evidence to you under Rule 9 of the Inquiry Rules on 2 May this year. In response to that request, and following a meeting with members of the Inquiry team on 7 May this year, you have provided a witness statement to the Inquiry. Is that right?

A. That's correct.

Q. You should have in front of you a copy of that witness statement that is 13 pages long.

A. Yes.

Q. At page 13, the final page of your statement, you will see that it is dated 2 July of this year. Is that right?

A. Yes, that is correct.

Q. And just above the date you made a statement of truth and then signed the witness statement on that same page.

A. Yes.

Q. Have you had an opportunity to read the statement through?

A. I have.

Q. And is that document true and accurate to the best of your knowledge and belief?

A. It is, yes.

Q. As you know, that witness statement will therefore stand as your evidence to the Inquiry, and although I am going

to ask you some questions about the witness statement, I am not going to take you through it line by line or ask you to read it out.

A. Okay.

Q. Please do be assured, however that the Chair and the Inquiry team have read and considered everything you say in that statement very carefully, and it will form part of the body of evidence on which this Inquiry will rely.

A. Okay.

Q. I would also like to acknowledge that you have, in November last year, provided a commemorative and impact account about Keith and that was read for you.

A. Yes.

Q. The Inquiry is extremely grateful for that evidence as well as the evidence you are giving today.

A. Okay.

Q. I would like to remind you that I will not be asking you to name any individual staff member today, so please try not to do so. If at any point you require a break, please bring that to my attention.

A. Will do.

Q. Please try and keep your voice as loud as you comfortably can so that your answers are captured on the transcript.

A. Okay.

Q. Your evidence will focus on your concerns in relation to

Keith's care and treatment under the care of the Essex Partnership University NHS Foundation Trust or EPUT.

A. Okay.

Q. Before we go through your evidence, I want to make clear that you have prepared your witness statement to give as full an account as you can, and that it is based on your recollection of what you saw and experienced at the time. Is that right?

A. That's correct.

Q. And what you were told by Keith. Is that right?

A. Correct.

Q. As well as impressions your mother and your aunt had at the time?

A. Correct, yes.

Q. It is also based, do I understand correctly, on your consideration of some documents that you had not seen at the time, but you have seen more recently?

A. That's correct.

Q. And in particular you refer in your witness statement at paragraph 26 to having seen EPUT's root cause analysis investigation report as well as care notes obtained via a subject access request. Is that right?

A. That's correct.

Q. I now want to summarise a timeline of key dates taken from your witness statement, and please do stop me if I

summarise incorrectly or if there is something you want to add.

A. Okay.

Q. Please do feel free to refer to your statement as you wish throughout my questions.

A. Okay.

Q. Taking all these matters from the information you have provided to us in your witness statement, in 1981 when Keith was 24 years old, his father died unexpectedly in a road traffic accident and it is your belief and that of your family that it was after this tragic event that Keith started to struggle with his mental health.

A. That's correct.

Q. Keith would often get quite anxious and over time Keith's struggles with his mental health became more apparent.

A. Yes.

Q. He was worrying about others having road traffic accidents and expressing that he was not worthy of love.

A. Yes.

Q. In 1990 or 2000 when Keith was around 42 or 43 years old he had a breakdown.

A. Yes, correct.

Q. He was diagnosed with depression by his GP and was prescribed propranolol.

A. Correct.

Q. In early 2003 Keith suffered another breakdown. At this point Keith's wife contacted your family to ask for help; is that right?

A. Yes.

Q. Shortly thereafter, Keith was referred by his GP to a senior house officer at the Linden Centre in Chelmsford.

A. Correct.

Q. He was assessed and diagnosed with endogenous depression and anxiety and referred for cognitive behavioural therapy, family therapy with his wife, behavioural psychotherapy and anger management classes.

A. Correct.

Q. Between 2003 and 2006 Keith attended therapy sessions at the Linden Centre and the Chelmsford and Essex Centre.

A. Correct.

Q. During this period you understand that Keith's mental health improved.

A. Yes.

Q. Around 2006 Keith's therapy sessions were discontinued.

A. Yes.

Q. Keith contacted a psychiatric nurse to ask whether he could continue with the therapy sessions as he felt they were doing him good, but was instead given a number to call if he was feeling down.

A. That's correct.

Q. For a few years Keith pulled away from the family, who wanted to respect his desire to deal with things on his own, and over that period you were not in close contact with him; is that right?

A. That's correct.

Q. And is it right that this period, that you refer to in your statement, was around 2007 to 2018?

A. That's correct, yes.

Q. And during this period, as far as you can recall, you understand that Keith continued to take medication and have mental health medication reviews but did not otherwise engage with mental health services.

A. That's correct.

Q. You describe him as becoming increasingly isolated and limiting who he would speak to and what he would say.

A. Yes.

Q. In around October 2018 Keith's marriage ended.

A. Yes.

Q. He moved out of the marital home and began living alone in rented accommodation.

A. Yes.

Q. Between the end of 2018 and early 2019, Keith became very unwell.

A. Yes.

Q. Keith's antidepressant medication was due to be reviewed

in February 2019, but no review took place.

A. That's correct.

Q. On 26 March 2019 Keith attempted to take his own life by making a laceration to his right wrist.

A. Correct.

Q. He was found in his kitchen and taken to the A&E department at Broomfield Hospital.

A. That's correct.

Q. He was then admitted to the Mayflower ward, which was a surgical unit, and on 28 March 2019 he underwent surgery to repair the damage caused to his arm.

A. That's correct.

Q. On 29 March, Keith was then assessed by the mental health liaison team at Broomfield Hospital.

A. Correct.

Q. Following the assessment, the decision was made not to admit Keith for mental health treatment and instead to refer him for urgent brief intervention through the community-based Access and Assessment Team.

A. That's correct, yes.

Q. Keith wished to remain at hospital, but was discharged from the Mayflower ward following treatment for his physical injuries that evening.

A. Yes.

Q. Walking three miles alone to get home.

A. Yes.

Q. And no family members were notified of his discharge.

A. No, none of us.

Q. On 31 March your mother contacted the Access and Assessment Team as she was concerned about Keith.

A. Correct, yes.

Q. The Access and Assessment Team then called Keith and when he did not answer they called the police to request a welfare check.

A. Correct.

Q. When the police declined to assist on the basis there was no immediate risk to life, a nurse from the AAT visited Keith at home.

A. Correct.

Q. He eventually came to the door and the meeting was recorded as a successful contact.

A. Correct.

Q. On 2 April your mother again contacted the Access and Assessment Team, who then called Keith five times without receiving a response.

A. Correct.

Q. On 3 April following two further attempts to call Keith, a nurse from the Access and Assessment Team visited him at home.

A. Yes.

Q. During the visit Keith consented to a referral to the Access and Assessment employment specialist, agreed to receive further support from the Access and Assessment Team via the brief intervention and that he would benefit from a medication review.

A. Yes, correct.

Q. On 9 April, after several unsuccessful calls, an Access and Assessment nurse visited Keith at home.

A. Yes.

Q. On 16 April the same Access and Assessment Team nurse visited Keith, who again reported that he felt better, but remained concerned about his job and impending divorce.

A. Yes, that is correct.

Q. It was agreed that Keith would contact his work to discuss an occupational health referral and seek legal advice in respect of his divorce?

A. Yes, that is correct, but he wasn't able to do that.

Q. Yes. On 23 April an occupational therapist called and left a message for Keith.

A. Yes.

Q. On the same day Keith told you that a call with his manager at work had been not very positive.

A. Yes.

Q. On 24 April the following day, Keith died by suicide.

A. Correct.

Q. On that same day, an Access and Assessment Team nurse had called Keith unsuccessfully and then made a home visit but got no response and took no further action.

A. Correct.

Q. Thank you. Now we have set out the timeline of Keith's involvement with Essex mental health services, I would like to ask you some questions regarding your concerns.

A. Yes.

Q. I am going to go through these thematically, and I would like to start by asking you about your concerns in relation to Keith's mental health assessment and the decision to discharge him on 29 March 2019.

A. Yes, so none of us were contacted, not his daughter or his wife at the time, and there was no communication between the hospital and the mental health team to say that they were discharging him. They just said they needed the bed and let him go, walk home.

Q. And so he was assessed on the 29th, having undergone surgery the previous day --

A. Yes.

Q. -- to repair the damage to his arm.

A. Yes.

Q. In terms of that assessment, is it right that none of the family was present, but you understand from the records

you have seen that he reported feeling depressed due to breakdown of his marriage.

A. Yes.

Q. And stated that the decision to harm himself had been a moment of madness.

A. Exactly, yes.

Q. And assured the team that it would never happen again.

A. Yes.

Q. The decision was made not to admit him and instead to refer him for, what you understand, to be urgent brief intervention --

A. Correct.

Q. -- through a community-based Access and Assessment Team.

A. Yes.

Q. You explain in your statement that you would have expected any mental health team assessment to have involved contact with Keith's family; is that right?

A. Yes.

Q. And as far as you were aware, were any efforts made to contact your family during the assessment and before Keith left hospital?

A. No, no attempt to contact any of us no.

Q. Do you know if efforts were made to contact Keith's ex-wife during the assessment or his daughter?

A. No.

Q. No you don't know or --

A. No attempt, no.

Q. In terms of the decision not to admit Keith for in-patient mental health treatment, as you express in the statement, it is your view that Keith should have been admitted.

A. Mm hmm.

Q. And that the system failed but not doing so?

A. Yes.

Q. Why is it that you say that?

A. Because it was quite obvious to me to harm yourself in that way, and to express to nurses that he felt down and he felt depressed, but he felt safe within a hospital environment, to me it made sense for him to be looked after by the mental health team and to be admitted.

Q. And you say about what Keith expressed at the time, is it right that the decision to discharge him was made despite his request to remain in hospital to receive treatment for his mental ill health?

A. Yes, he asked, he said he felt safe there.

Q. Is that your understanding from the medical records?

A. Yes.

Q. Or from what you were told by Keith thereafter?

A. Both. Keith told me as well that he felt safe there.

Q. Are you able to say more in terms of what Keith told you

when he was discharged?

A. He just said, "They discharged me but I was getting food and I was warm and there was people looking after me and I asked to stay but they needed the bed."

THE CHAIR: Did he comment at all on what was written in the records, that it was a moment of madness and that it wouldn't happen again? Did he refer to that?

A. He never mentioned that to me. He used to say to me that basically he done it wrong, what he did he done it wrong.

THE CHAIR: What did he mean by that?

A. His intention was he didn't want to be here, I think, and --

THE CHAIR: So that rather contradicts --

A. Yes.

THE CHAIR: -- what he told them or what he is recorded as telling them?

A. Yes, yes, exactly.

THE CHAIR: Thank you.

MS LLOYD-OWEN: So when Keith was discharged you have mentioned that he understood that that was because of a shortage of beds?

A. That's what he told me he was told, yes.

Q. And that is in relation to the Mayfair -- Mayflower Ward, as you understand it?

A. Yes.

Q. So the surgical ward that he was on?

A. Yes.

Q. And so at this point, as you have set out in your statement, Keith was then discharged at around 6.30 pm that evening; is that right?

A. Yes, correct.

Q. From the records you have seen, is there any indication that there was a discussion between the Mayflower Ward and the Mental Health Liaison Team, or within the relevant teams, of the timing or steps to be taken ahead of Keith's discharge?

A. Nothing that I have seen. Later on at the inquest, at the Linden Centre, they said they hadn't had communication from the hospital that they were discharging.

Q. So this is the Mayflower Ward not contacting the Access and Assessment Team?

A. Yes, yes.

Q. Whose care he was going to be under in the community?

A. Yes.

Q. And you have explained already that you were not informed of Keith's discharge nor, to your knowledge, were any other members of the family?

A. No, nobody.

Q. Nor his ex-wife or his --

A. Or his daughter either, no.

Q. And you explain in the statement that this meant that no arrangements could be made for Keith to be collected from the hospital.

A. Yes.

Q. And are you able to say something about what the consequence was for Keith that effectively he was left to make his own way home; is that right?

A. Yes, he walked about three miles from the hospital to his home, along very busy roads. He also walked along a river. So you know, to me, to be in that state of mind, that was incredibly dangerous for him. You know, a few days before he had done that to his arm with the intention, I see it, as ending his life, but then he was allowed to walk along very busy road and along beside a river and he could have done anything.

Q. And if a call had been made to you or a member of the family or to his ex-wife or to his daughter?

A. Yes.

Q. What would have happened?

A. We would have gone and collected him. The family home is two minutes from the hospital, literally around the corner.

Q. Is it right that your family had been trying to contact Keith at this point while he was in hospital?

A. Yes.

Q. And you explain in your statement that when your mother called and got through to the Mayflower Ward, the ward staff were unable to give much information due to confidentiality reasons but they confirmed that Keith had attended the hospital and since been discharged.

A. That's correct.

Q. And is it right that your mother then phoned the Access and Assessment Team at the Linden Centre?

A. Yes.

Q. And was told at that point that they were not aware that Keith had been discharged?

A. Yes, that's correct.

Q. And as you say, and it also was referred to at the inquest, that there appeared to have been no communication between the Mayflower Ward and the Community Mental Health Team before Keith --

A. Yeah, no communication.

Q. -- took his journey on his own.

A. Yeah, no communication at all.

Q. I want to turn now to ask you some questions about the community care that Keith received.

THE CHAIR: Can I just ask one question about the family and what the hospital may or may not have known about the family. Did Keith say anything about whether he had

given permission for the hospital to speak to the family at all?

A. He never mentioned that to me. His daughter had been into the hospital the day before to visit him, so they were aware that there was a daughter.

THE CHAIR: Who cared and was there.

A. Yes, but as far as I'm aware, they never asked him, or he never said.

THE CHAIR: And you are not aware of any instructions he may have given not to contact the family?

A. No, I'm not aware of that, no.

THE CHAIR: Thank you.

MS LLOYD-OWEN: Thank you. From your knowledge at the time or from the records you have seen, are you aware of any records to indicate a discussion with Keith about sharing information with his family?

A. Nothing. He never mentioned anything to me or any other family member that visited and I haven't seen anything in any of the notes that I requested.

Q. Thank you. In terms of the treatment Keith was to receive, which you understand to have been urgent brief intervention through the community based Access and Assessment Team, was it your impression when speaking to Keith after his discharge that he understood what this meant, what he could expect to receive in terms of care

and support?

A. He didn't understand anything. He just wasn't in that frame of mind. He just laid on a settee all day with a quilt over him. He wasn't aware of anything happening around him. He would worry about stuff. So for anyone to give him an instruction or tell him what may be happening it's like he couldn't comprehend it. He just, yeah.

Q. And so is it right that you never saw any kind of discharge plan or written information to explain what the intervention and support he was going to receive would be?

A. No, I never saw nothing from the mental health side, but obviously just discharge appointments from the hospital. That's all I ever saw.

Q. So what you saw was in relation to his physical --

A. For the wound.

Q. -- physical treatment and recovery rather than anything in relation to his mental health?

A. Nothing else, no, yeah, only that.

Q. Did you speak to Keith, you or other family members, speak to Keith about what the expectation was and what the treatment he was due to receive would look like and the support?

A. We did, but again he just didn't understand it. He

didn't understand. I think maybe he may have said something like possibly, "Oh they will come round", but, yeah, he didn't really understand what they had told him.

Q. Following Keith's discharge from hospital, you explain that your family all visited and supported Keith.

A. Yes, yes.

Q. Prior to that and earlier in your statement you describe Keith as an extremely private person and explain that he had previously pulled away from the family.

A. Yes.

Q. So there was that period of time when you weren't in close contact with him.

A. Yes, he didn't like to be seen as a burden and that's within his medical notes and he has also said that to me as well. He didn't want to come across as a burden to the family.

Q. And so what was the position or state of contact at the point he went into the hospital on 26 March?

A. Messages about -- then when we knew that he had been discharged we just went to the house where he was live.

Q. So effectively once the family knew he was in crisis and there had been --

A. Oh yes, straight away.

Q. In terms of the contact that there was following his discharge on 29 March you explain in your statement that

the family all visited and supported Keith.

A. Yes.

Q. Are you able to tell us more about the regularity of that, who was involved and what that looked like on a day-to-day basis?

A. Yes, so we kind of done it in shifts. So it was myself or my husband, or my auntie and her husband, or my mum. So his two sisters, myself and my husband, we would sort of go round every day, two three times a day, to make sure he was eating, to try and get him to do things, you know, just basic life stuff, you know. Do washing, have a shower, that kind of thing. It was a struggle. It was hard, but yes we were there majority of the time.

Q. And you explain in your statement that you were particularly focused on getting him out of the house to attend appointments; is that right?

A. Yes, to get him to the hospital and you know go to the bank and go to the GP, but it was very hard to get him out of the front door.

Q. And in terms of your assessments, your experience of Keith's behaviour and mood over the month between his mental health assessment and his death, you explain that Keith had trouble sleeping at night and was sleeping throughout the day. I think you referred to him being under a blanket.

A. He would sleep downstairs. He didn't like going upstairs, so he would have a big quilt on the sofa in the day, sleep the majority of the day, never ate unless we took stuff round, picky stuff for him to eat. Unkempt. He was always a very presentable person but he just looked completely different, completely different.

Q. Turning to the support that Keith was receiving from the Access and Assessment Team, it's right that you set out in your statement that the team visited and telephoned Keith on several occasions --

A. Yes.

Q. -- between his discharge from hospital on 29 March and his death on 24 April?

A. Yes.

Q. Is it right that their attendances is something you have largely pieced together from records?

A. Yes.

Q. And those are limited to those which we outlined in the chronology earlier.

A. Yes, correct.

Q. So effectively a coming to the door on 31 March.

A. Yes.

Q. As you see it is described as a successful contact. Visits on the 3rd, 9th and 16th April.

A. Yes.

Q. And then a failed attempt to visit him on the 24th, which is the day that Keith died.

A. Yes, that is correct.

Q. Given your own visits to Keith and how he appeared, you set out in your statement that you felt it must have been immediately evident to the Access and Assessment Team staff that Keith was not well and that they should have done more to help him.

A. Yes, I do definitely.

Q. One of the concerns you express about the Access and Assessment Team contact with Keith was that it appeared to occur at random --

A. Yes.

Q. -- with no consistency, and that Keith was never sure whether or when somebody would be coming to see him.

A. Yes, we never knew, it could be the morning, the afternoon, they never sort of wrote anything down for a family member to see to say we are going to come out on this day, nothing.

Q. And so was this something that you discussed with Keith or other family members at the time or something you have understood subsequently from the medical notes?

A. Yes, it's from the notes and also we just, we just never saw anyone. There was just never -- we were there the majority of the time, but yeah.

Q. And the impression you got, as you express in your statement, was that visits by the Access and Assessment Team to Keith were only prompted by your mother calling to register her concern for Keith's wellbeing.

A. Yes, that's correct.

Q. You say that you wonder whether if your mother had not been making those calls Keith would have received any support at all?

A. Yes, I do believe that, yes, I don't think he would have.

Q. Again is this something that you appreciated at the time or in fact something you have seen from the records and now are noting when those meetings and attendances were?

A. Yes, I think from the records because obviously we weren't informed at the time of when they had been and where they have attempted to see him. So yes, looking back when I have requested all the records you can see the dates and the information they have provided.

Q. Yes. You have set out in your statement, very helpfully, a summary of the contact with Keith, including information you have since learnt from his care notes and EPUT's "Root Cause Analysis Investigation Report". I want to look specifically at the visit from an Access and Assessment Team nurse on 3 April, and then a visit on 16 April.

A. Okay.

Q. This is at paragraph 29 of your statement, which is on page 7, I believe. And you outline here the visit on 3 April which followed a call to the Access and Assessment team from your mother --

A. Yes.

Q. -- the day before, raising concerns that he had no support and the family thought he was at risk.

A. Yes.

Q. So although what you have described as not much communication coming the other way --

A. Yes.

Q. -- is it your evidence that communication was going to the Access and Assessment Team from family?

A. Yes, because we were so worried about him.

Q. And that was through calls, principally from your mother; is that right?

A. Yes, yes.

Q. To the Linden Centre --

A. Yes.

Q. -- or to the office there.

A. Yes, yes.

Q. To communicate the level of risk and concern that you had.

A. Completely, yes.

Q. Now, following a call from your mother, there was then a

difficulty in getting hold of Keith by the phone and when they couldn't get hold of Keith there was a visit arranged to his home address on 3 April.

A. Yes, correct.

Q. From what you have seen in the records you understand that all the curtains were closed and there was no initial response from Keith; is that right?

A. Yes.

Q. Keith eventually appeared at an upstairs window and opened the back door appearing unkempt.

A. Yes.

Q. Now you have already explained that you didn't know when they were coming and you didn't see them. Is it right that on the visit of 3 April, that is the one occasion where in fact your aunt happened to attend at the same time and therefore she saw --

A. She did.

Q. -- the interaction between Keith and the Access and Assessment team?

A. Yes, she did. It was literally by chance, she had gone round to be with him and, yes, they turned up, so she was there.

Q. And so your assessment, is it fair to say, of how the Access and Assessment Team staff interacted with Keith is based on what your aunt has told you --

A. Yes.
Q. -- about her impression of this experience?
A. Yes.
Q. Of course as well the records --
A. Yes.
Q. -- and the other things you have seen subsequently?
A. Of course.
Q. You understand that during the visit Keith reported feeling low and worthless and accepted that his current thinking put him at risk of suicide.
A. Yes.
Q. And is that something that your aunt communicated or you have seen in the records?
A. My aunt, yes.
Q. He also expressed that he was worried about his marriage breakdown, his finances, potentially losing his job as a train driver because of his recent injury --
A. Yes.
Q. -- and his wife and daughter moving out of the area to live with his wife's new partner; is that right?
A. Yes, that's correct.
Q. You set out in your statement that your aunt found the Access and Assessment Team nurse was not welcoming of her input; is that right?
A. That's correct.

Q. And you give a particular example which was, is that right, communicated to you by your aunt?

A. Yes.

Q. Of a nurse smirking when your aunt asked about the possibility of Keith returning to work?

A. That's correct, yes. That was his biggest worry, was going back to work and that was brought up into the conversation and the member just sort of smirked and went sort of, you know, made a face, which upset him massively.

THE CHAIR: His worry in the sense that he wanted to go back?

A. He wanted to go back but in his eyes he didn't think he was ever going to go back. So that was kind of one of his -- that and the divorce, that was the biggest worry and they just advised -- with the divorce they just said when the envelope comes through the letterbox make sure someone is with you. And that's how that was left.

MS LLOYD-OWEN: And you contrast in your statement that experience of the smirk from the nurse attending --

A. Yes.

Q. -- with an experience you had when you took Keith to receive treatment for his physical recovery.

A. Yes.

Q. And you describe there a very different experience. This is at paragraph 33 of your statement, where you describe

taking Keith to the Broomfield Hospital for an outpatient follow-up check on how his wound was healing.

A. Yes.

Q. And again there is a focus on this issue of whether or not Keith can return to work.

A. Yes.

Q. And you say:

"To mitigate Keith's growing concern about his job" -- you asked the nurse -- "whether she could provide a letter confirming that he was okay to return to work."

A. That's correct.

Q. "The nurse was extremely empathetic and said that she would do so, so long as I promised that Keith was getting help."

A. That's correct.

Q. And you cite that as an example of the kind of care that you see as positive and supportive --

A. Yes.

Q. -- and appropriate; is that right?

A. Yes, yes.

Q. You say here you were grateful for her concern and in all of your interactions with EPUT, "felt that she was the only person to be kind, considerate and sympathetic to Keith's situation."

A. That is correct.

Q. Now we will come on to and it is right to say that your interactions with EPUT principally followed Keith's death.

A. Yes.

Q. We will come on to that. But this was the example, you would say, of what should have happened in terms of interactions.

A. Yes, exactly. She showed a lot of empathy for my uncle and spent time talking to him and then obviously talking to me.

Q. Turning back to 3 April, during that visit from the Access and Assessment team nurse, Keith agreed, is this right, that he could benefit from someone to talk to and consented to a referral to the Access and Assessment Team employment specialist?

A. Yes.

Q. And it was also agreed that Keith would receive further support from the Access and Assessment Team via brief intervention.

A. Yes.

Q. Again, is it your understanding that this -- it was not clear to Keith or your aunt what this brief intervention would involve?

A. Yes. There was no sort of explanation, obviously my uncle wouldn't have been able to comprehend what they

were saying at that time, but my auntie said there was very lack of information around that. They just sort of said it and that was kind of it. No more than that.

Q. And did your aunt ask about that and what that amounted to?

A. I'm not sure, she never mentioned that to me. She just said that obviously after the way that they dealt with him when he asked about his job, you are then consoling him and, you know, he was the priority at that time. So she's not mentioned that she mentioned it, but I think she was more looking after him.

Q. So her focus was elsewhere --

A. Yes.

Q. -- and on consoling Keith at that point.

A. Yes, but no information was left or anything for anyone else to read or anything.

Q. And you have mentioned the importance of Keith's work to him and his fear about never being able to go back to that work.

A. Yes.

Q. And we have seen here clearly that there was a referral to the employment specialist agreed to by Keith.

A. Yes.

Q. From the records you have seen, from your knowledge, do you know what, if any, support Keith received from any

employment specialist before his death?

A. Nothing.

Q. Have you seen anything in the records to indicate that the referral was made and acted upon?

A. Not that I have seen in the records, no.

Q. Do you feel that there was an appreciation by the staff attending on that date of the significance of Keith's employment as a risk factor for him, as something that was really important to him at that time and a focus of his concerns?

A. No, I don't think they took that into consideration at all. No, their whole reaction was as if, it came across, so my auntie said, that you know basically after what you have done to your arm you won't drive a train again. That's the impression my auntie took from the response so no, they weren't understanding to his concern.

Q. You were obviously visiting very regularly at the time, your husband as well --

A. Yes.

Q. -- and other family members. Did Keith speak to you or other family members about his concerns about work?

A. He did, and I contacted his employer at one point and spoke to them because he was worrying so much about it, and they were lovely and I went back to tell him and said, "You know they understand." I didn't go into

detail about what happened, "They understand, they wish you well." But again he couldn't comprehend that, he couldn't take that someone was being nice to him basically.

Q. I want to turn now to your paragraph 32 which relates to the 16 April visit from an Access and Assessment Team nurse at home. As he had on the 9 April visit, you understand that Keith again reported that he felt better but remained concerned about his job and impending divorce.

A. Yes.

Q. And he was particularly concerned about the divorce papers arriving in the post. Is that right?

A. Yes.

Q. Is that something you know from what you directly heard from Keith?

A. All the time, all the time.

Q. So whilst you were visiting him over this period, this was something he was raising regularly?

A. Yes, he was just so worried about them coming through the letterbox.

Q. And is it your understanding from the notes of that meeting that he was advised to have a friend or family member with him when he opened the divorce papers?

A. Yes.

Q. And is it right that you understand that he denied ever feeling suicidal and expressed that he had no thoughts or plans to harm himself in that meeting as it is recorded?

A. As I have seen it recorded, yes.

Q. You understand from Keith's care note that actions were agreed for him to take forward, again, this is from the note; is that right?

A. Yes, yes.

Q. And these included contacting his work to discuss an occupational health referral and seeking legal advice in respect of his divorce?

A. Yes, I have seen that in the notes and they said that to him and again he wasn't able to do those kind of things.

Q. What was your memory at this point, so we are moving forward to 16 April, so midway through that month, when you had been visiting regularly, what was your memory of how Keith was managing day-to-day tasks at the time?

A. He wasn't managing at all, he wasn't managing. He wasn't having showers, he wasn't washing his clothes, he wasn't eating. He didn't leave the house unless by chance I was able to get him out for some reason. Yeah, he just wasn't coping at all.

Q. And you say in your statement at paragraph 32 that in those circumstances, you do not think it was helpful or a good use of time for him to be told to action certain

things and then left to do them by himself?

A. Yes, he was incapable to do them by himself.

Q. Had that been something which was an action raised with you, as family members? Is that something you feel you could have supported him to do?

A. Definitely, definitely, because we were working on -- well I was with him doing so much, trying to change his GP, trying to get him medication reviews, things like that. So I definitely would have helped him, most definitely.

THE CHAIR: Would it have been obvious if you had seen Keith at that stage that he was struggling with --

A. I think so.

THE CHAIR: You mentioned his clothes not being washed.

A. Yes.

THE CHAIR: And him not --

A. Yes, the house was untidy, the curtains were pulled all the time, where he would lay with the quilt, laid on the sofa, and it was apparent that's where he was sleeping in the day. So I think even if you didn't know him, as a stranger, you would pick up those signs, definitely.

THE CHAIR: Thank you.

MS LLOYD-OWEN: In terms of the limitations of the support he was being given by Access and Assessment, the team, is it right that at this time Keith's mobile phone was broken?

A. It was, yes.
Q. So there were instances where the team were unable to reach him by telephone?
A. Yes.
Q. Which we see in the records, but can you say whether or not that is because he wasn't picking up or because in fact his phone wasn't working at that point?
A. It wasn't working because we had to go and get him a new phone. Me and my auntie, we had to go into town to get him a new phone.
Q. Can you recall when in the month that happened?
A. Probably mid-April time that happened, but again I think my mum, from what my mum told me, she did contact them to say his phone wasn't work.
Q. So you had done what you could to communicate the fact that calling him was not going to be of any use --
A. Yes.
Q. -- because he effectively couldn't answer.
A. His phone was broken, yes.
Q. I want to turn now to 23 April, and if it assists this your paragraph 35, is it right you have seen from the records that an occupational therapist called Keith on that date and left a message?
A. Yes, I have seen that in the records, yes.
Q. And that is the same date that you spoke to Keith for the

last time?

A. Correct.

Q. And he told you that he had had a call with his manager at work and it had been not very positive?

A. Yes.

Q. The following day, on 24 April, the data Keith died by suicide, an Access and Assessment Team nurse had at attempted to call Keith, as you see it from the records.

A. Yes.

Q. And again, as you see it from the records, is this right, later made a home visit but was unable to make contact.

A. Yes, that is correct.

Q. At that point, is it your understanding that this was the first time they had made a home visit and been unable to actually make contact with him?

A. I believe so, yes. Obviously from the records I seen, but I believe so.

Q. So from the records is it your understanding that, although on previous occasion he hadn't come down immediately and it may have taken some time, this was the only occasion where he didn't come down at all.

A. There was the other occasion where they contacted the police who said they were unable, yeah.

Q. So this may be -- yes and in fact --

A. Yes.

Q. Is it right that when they contacted the police and asked them to attend --

A. Yes.

Q. -- they had said that they wouldn't attend because there wasn't an immediate risk to life?

A. Yes, that is correct.

Q. That was the understanding that you have, again from the records?

A. From the records, yes.

Q. Now, after the Access and Assessment Team nurse attended Keith's address on the 24th, and got no answer, is it your understanding that she did not call the police and that there was no contact made to any family members?

A. That's correct, nothing. No contact.

Q. And again are you aware of any efforts made to call Keith's ex-wife or his daughter?

A. No, nothing, nothing at all.

Q. On that same date, 24 April, is it right that you as family members were also trying to contact Keith?

A. Yes. My husband was trying through the day and then when I came home from work that day, my husband said, "Have you spoken to him?" Obviously I hadn't. So my husband went straight back round, back round to the house.

Q. And when there was no response from Keith, is it right that your husband broke through the door, got into the

address and found Keith at that stage?

A. Yes, he went to the back door and looked through. He saw that the front door was locked from the inside and his phones were on the side. My husband phoned me and I said, "Just get in", which is what he done and yes, found him.

Q. Thank you. I want to move to discuss a little bit move about the extent and quality of interactions between AAT staff and your family. We have covered this largely already, but I want to just clarify is it right that on 2 April, after visiting Keith the previous day when he seemed very unwell and dishevelled, your mother called the Access and Assessment Team to find out what had been put in place for him moving forwards?

A. Yes, my mum was in a job role when -- she used to be working in a residential home, so she had dealings with the mental health side with the residents, so she knew what to do and what to say. So my mum was the main person by phone contacting them.

Q. And the Access and Assessment Team or the Linden staff that she spoke to, is it right that they told her that they would not give your mother information about Keith without Keith's express consent?

A. Yes.

Q. But agreed to call and check in with Keith?

A. Yes, correct.

Q. Is your understanding that they were effectively agreeing to speak to Keith separately and find out whether or not he was okay, given the concerns your mother had raised?

A. Yes, that is correct.

Q. And this is something you understand from discussions with your mother. Is that right?

A. Yes, yes.

Q. As far as you are aware, from the records you have seen and knowledge you have, did any member of the Access and Assessment Team staff or Linden Centre staff talk to Keith about whether he would consent to share information following that discussion with your mother where they said, "We have to check about consent."

A. No, in discussions with Keith he never mentioned that to me. I have never seen anything in any of the records.

Q. And was information sharing ever discussed with your family, as far as you are aware?

A. No, nothing.

Q. Were any steps taken at any stage to engage with your family and involve you in decisions regarding Keith's care?

A. No, nothing at all. Not even on the day my auntie was there when they turned up.

Q. You described family, and particularly your mother,

raising concerns about Keith being at risk in your statement?

A. Yes.

Q. And so what, if anything, were your family told by the Access and Assessment team, or indeed the Linden Centre when your mother was calling, about a crisis or safety plan for Keith, by that I mean what measures to take if concerns over his risk escalated?

A. They didn't really inform her. All they said is that they would call round, is it cold call or something like that, that's what they would do. They would go and check on his welfare.

Q. So the only connection point, as you understood it as a family, is this right, was that you could call the Linden Centre --

A. Yes.

Q. -- and notify them about your concerns for them to deal with separately?

A. Yes.

Q. So effectively you were providing familial support, and then they were providing separate support, but there was no connection between the two?

A. No, and they only provided that when we called and we sort of prompted them.

Q. In terms of the value placed on the information that your

family had to share about Keith, was it your impression, again from the calls your mother made or from your aunt's attendance that this was valued by the Access and Assessment team staff, that the family members interacted with?

A. No, not really. We never felt supported or that it was going to be effective in any way, really.

Q. So is it right to say that you feel that there was no opportunity for you to have any meaningful involvement with Keith's care?

A. No. No opportunity.

Q. If we look at your paragraph 46 of your statement, which is at page 12, where you set out some reflections, you express your belief there that services need to work with families to make decisions about appropriate mental health care and treatment?

A. Correct.

Q. And that you, as a family, were not engaged with in a meaningful way?

A. That's correct.

Q. And you say that, at the very at least, services must make sure that family members are aware of the care plan in place.

A. Yes.

Q. Which was not the case in Keith's case?

A. No, nothing, never saw anything or heard anything.
Q. And you also say there that a family support network should be utilised to ensure a person's safety.
A. Correct.
Q. You point to the fact that Keith's family could have been a means of contacting Keith when he was not picking up calls from AAT?
A. Yes.
Q. And you also specifically point to the family being able to have collected Keith from Broomfield Hospital to avoid him walking home vulnerable and alone.
A. Yes, definitely.
Q. We have already discussed what you describe as what perhaps good communication with family members and patients would look like.
A. Yes.
Q. By way of your example of the out-patient appointment.
A. Yes.
Q. And you describe there that Keith was reluctant to attend, but was put immediately at ease by the nurse who saw him?
A. He was. It was hard to get him to that appointment, but I managed to get him there. Yes, as soon as this lovely nurse was talking to him, you could see he was just at ease.

Q. Against this, you have described your aunt's experience of the Access and Assessment Team nurse, who was visiting Keith on 3 April as unwelcoming and insensitive?

A. Yes.

Q. And that is what you're your aunt communicated to you; is that right?

A. Yes, yes, completely.

Q. As a consequence of your family's experience, you recommend, at paragraph 47, directly following, that staff are trained in how to appropriately talk to patients and their family at what is such a difficult time.

A. Correct, definitely.

Q. I want to look back quickly at paragraph 43, and here we see the root cause analysis investigation report that you referenced here, which I understand you have had sight of and from that you have seen that it recommended that a patient's next of kin --

A. Yes.

Q. -- should be confirmed at their initial assessment and updated in the patient records.

A. Yes.

Q. To the best of your understanding, what was the position with Keith's next of kin, at the time he went into hospital, and indeed thereafter until the point of his

death? Do you know who was listed as his next of kin?
A. It was his wife at the time. But even though the relationship is quite strained, she had no communication from anyone. She told me that.
Q. Is it right that, in fact, when Keith had been found following his suicide attempt on the 26th March, he was found by one of his ex-wife's friends --
A. Yes.
Q. -- who contacted his ex-wife --
A. Yes.
Q. -- who contacted you as family?
A. Yes, that is correct.
Q. So there was that connection, is it right?
A. Yes.
Q. The ex-wife knowing to contact the family --
A. Yes.
Q. -- if there was a concern.
A. Yes, and with next of kin the week that my uncle passed, I was planning -- I had a GP appointment to take him to review his medication, and he was quite happy for me to step in as next of kin, but obviously that didn't happen.
Q. I want to turn to the topic of medication briefly, which you raise considerable concerns in relation to. That is in particular the responsibility for monitoring Keith's antidepressant medication.

A. Yes.

Q. You understand that Keith had been prescribed the antidepressant medication Sertraline in 2018?

A. Yes, correct.

Q. And that was due to be reviewed in February of 2019?

A. Correct.

Q. As far as you were aware, his medication was not discussed with him when he was admitted to the Mayflower Ward in March 2019; is that right?

A. That's correct.

Q. And you are not aware of any reviews of his medication having been conducted?

A. No, he never mentioned anything, nothing in his notes either.

Q. At the time Keith had recently moved address.

A. Yes.

Q. Came out of the marital home, is that right, and into rented accommodation.

A. Correct.

Q. And is it right that you were helping him to register with a new GP surgery?

A. Yes.

Q. He had an appointment scheduled for 29 March, at which time he was yet to be discharged from the Mayflower Ward.

A. Yes.

Q. You then managed to book an appointment for 25 April?
A. With a different surgery because the surgery he was with refused to see him because he was out of the area when I contacted them about medication.
Q. So he misses that appointment?
A. Yes.
Q. And then effectively you are waiting for him to be registered, enrolled, at a new surgery --
A. Yes.
Q. -- and then you have a new appointment for 25 April, so more than a month later or a month later?
A. Yes.
Q. You express in your statement, and if it assists you this is at paragraph 37 of your statement, which is on page 9, that in the meantime you had assumed that the Access and Assessment Team would be monitoring his medication.
A. That is correct, yes, I would assume that.
Q. You say that you anticipated this would include checking in to make sure Keith was taking his medication?
A. Correct.
Q. And you assumed that this would form an important part of any welfare check.
A. Yes, definitely.
Q. Were the Access and Assessment Team aware, as far as you can say, that Keith did not currently have a GP, he was

effectively between GPs at this point?

A. I don't even think they acknowledged it. There's nothing within the records of even talking to him about a GP.

Q. As far as you are aware, beyond getting Keith's agreement that he could benefit from a medication review, when the Access and Assessment Team nurse visited him on 3 April, did the staff speak to Keith about his medication at any other time?

A. Not that I'm aware of, no.

Q. And not that you have seen in the records?

A. Not in the records, no.

Q. As far as you were aware, were there any arrangements made to facilitate a review of Keith's medication from what you have seen of the records from what --

A. No, nothing, nothing.

Q. So in effect it is your understanding that no medication review was facilitated either during Keith's time at hospital or following his discharge?

A. That's correct and I think because the people visiting him were a different banding as well because within his notes it keeps saying that they request a higher band, so whether they were in the position to be able to do that, I'm not sure.

Q. So your question is you are not sure whether, in fact, those people who were visiting them, they might have been

able to recommend something for him?

A. Yes.

Q. But they might not have been able to authorise that?

A. That's correct because in the notes it kept saying, "We need a higher banding to visit."

Q. And it may be that's something which the medication review also required a higher banding for?

A. Yes.

Q. The tenor of the notes gives you that impression.

A. Yes, it's mentioned a few times, but yet no higher banding visited him.

Q. Thank you. You understand from your mother that she found a large supply of Keith's medication in a cupboard?

A. She did.

Q. And when asked, Keith admitted that he had not been taking it because he did not feel that it was working at that time.

A. Yes, that is correct.

Q. Are you able to say whether the Access and Assessment Team staff were aware that Keith had not been taking his medication?

A. My mum, I believe my mum did say that on a phone call to them after she had found it in the cupboard because obviously we were very worried, what he had around him, for his safety and that's when she found the medication.

Q. Are you able to say at what point in the month that took place, what time she will have communicated that?

A. I would say probably quite early on, early April.

Q. Thank you. You say at paragraph 37 that you are left wondering whether there would have been a different outcome had the Access and Assessment Team paid more attention to Keith's medication.

A. That's correct, yes.

Q. And you understand that, right, from the root cause analysis investigation report, that they recollected following a review of Keith's case, that a medication/medical review should be facilitated at soon as it is identified as being required.

A. Yes.

Q. And if this is not possible for reasons to be clearly documented in the patient's records.

A. That's correct.

Q. And you set out at paragraph 48, again in your reflections section on page 12, that you consider that it is essential that medication reviews are carried out without delay --

A. Yes.

Q. -- and considered out as part of any welfare checks in the community.

A. Yes, I do.

Q. I want to turn now to your concerns regarding the investigations following Keith's death.

A. Okay.

Q. Your family was asked by the Linden Centre to be involved in an investigation into Keith's death; is that right?

A. That's correct, yes, by phone call, they phoned up.

Q. And is it right that you agreed to act as the main point of contact for the family?

A. Yes, correct.

Q. You describe in your statement, and this section on what took place after Keith's death, starts at paragraph 39 on page 10, you describe in your statement at page 40 there that you had a meeting with the family liaison officer at the Linden Centre.

A. Correct.

Q. Which you understood was for the family liaison officer to introduce himself and for you to ask questions.

A. Yes, that is correct.

Q. What was your experience of that meeting?

A. I walked into the Linden Centre and was asked to wait in the foyer with lots of patients walking in and out, which after losing my uncle just recently as such, was very hard to see. I sat there for about ten minutes and then this man appeared, took me through to a quieter room and we just chatted. He basically said to me, "We could have

brought your uncle here but he would have still done the same thing", which I found a very harsh, very cold thing to hear. Then as we were sitting there talking, he sort of said to me, "How do you feel about your uncle? How do you feel about what has happened?" And I said I'm very proud of him, which he sort of -- his response was just "proud?" Sort of, you know, querying what I am saying really. Then an alarm went off and he said, "Do you know what that is?" I said "No", he said, "That's someone trying to harm themselves." So that was the initial meeting, and then as I left I just walked back to my car just crying.

Q. Thank you. You describe the meeting in your statement feeling like a box ticking exercise?

A. Oh definitely, definitely.

Q. And you describe the family liaison officer that you dealt with insensitive and the wrong person for that kind of role?

A. Yes.

Q. Is it right, as you set out in your statement, that but for the process of being in the process of putting Keith to rest at that time you would have made a formal complaint?

A. I would have, yes.

Q. Would it be fair to say that your capacity at that time

was taken up with grieving for and making arrangements for your uncle Keith?

A. Yes, definitely, definitely.

Q. At paragraph 41, you describe a meeting that you and your aunt attended in around June 2019 at the Linden Centre with a consultant psychiatrist --

A. Yes.

Q. -- the head of occupational therapy and the same family liaison officer. This was, you say in your statement "to discuss the care and treatment Keith had received".

A. Yes.

Q. You acknowledge in that meeting that you and your aunt were able to express how you felt let down.

A. Yes.

Q. And that your input was welcomed.

A. Yes.

Q. But is it right that, nevertheless, you found those at the meeting to be unapproachable, cold and unfriendly?

A. Very much so. Very much so.

Q. And looking back, are you able to help as to what it was that made you feel that way in the meeting?

A. Again, it felt just like ticking the box. They listened but there wasn't -- not a lot of empathy came across. Yeah, just three men there and it was just very cold, not friendly, not welcoming, no sort of expressing, you know,

they were sorry and things like that, for losing my uncle. There was just nothing. It was just an unfriendly experience.

Q. Yes. You then received a copy of the EPUT Root Cause Analysis Investigation Report; is that right?

A. Yes, that's correct.

Q. And when you received it, it included numerous inaccuracies --

A. Yes.

Q. -- which you then raised with the family liaison officer --

A. Yes.

Q. -- and you were then sent a corrected copy; is that right?

A. That's correct, and that meeting as well was also held in the Linden Centre, which again that didn't help, just seeing other patients struggling, it just wasn't, in my eyes, it wasn't the correct location to hold a sensitive meeting like that.

Q. Yes. And in that report, which you refer to in your statement at paragraph 43, the Trust acknowledged failings in Keith's care and identified where things could have been done differently.

A. Yes.

Q. And it made the two recommendations which we have

discussed already.

A. Yes.

Q. After the investigation concluded in July 2019, you did not receive any further communication from the family liaison officer or EPUT more widely; is that right?

A. No, nothing after that.

Q. Keith's final inquest hearing took place in the November of 2019?

A. Yes.

Q. Reaching a conclusion of suicide, with the cause of death recorded as hanging; is that your understanding?

A. Yes, correct.

Q. And is it right that you attend that inquest?

A. Yes, Keith's family attended that, so as a family we went to that.

Q. And are you able to say more about your experience of attending that inquest?

A. That process was very well dealt with, the lady, the contact with the lady that I had, she was very accommodating and I had communications with her even after the inquest. I requested to see pictures and things like that and she arranged that I could do that with her and she brought support in for me. They were just lovely, really, really lovely people, very accommodating and helped us through a tough time.

Q. And I think in your statement you say it's somebody in the Coronial office. Did you understand them to be the Coroner's Officer, or did you just know it was somebody there or perhaps more than one person?

A. It was one lady in particular, I can't remember her role, though.

Q. Not to worry. That's extremely helpful. The inquest itself, can you tell us a little bit about your experience of that, the actual hearing itself?

A. It was very short. The policeman that attended on the evening that my uncle passed away, he was there and read his sort of statement, as such, as evidence and then, yeah, the Coroner just said that it was -- well, actually on the certificate it is written that he killed himself, not suicide or took his own life, he killed himself by hanging, but, yes, very short, didn't go on for very long.

Q. And did you as family members ask any questions during that inquest?

A. I provided a statement. So before that day they did contact me and said, "Would you like to write a statement about your uncle, what he used to like, what sort of person he was?" So that was read out as well but that was mainly it.

Q. There was no questions asked by family members during the

hearing itself?

A. No, they were all very emotional and I think what I had written in the statement was enough. I think it covered everything we wanted to say.

Q. Thank you. Now we are going to go just quickly go through each of the recommendations set out in your witness statement.

A. Yes.

Q. And I will ask you if you would like to say anything further about them, or how they impacted on Keith's care and treatment. It may well be that you feel that we have covered them sufficiently already, but I would like to make sure you have an opportunity to say everything you would like to say in respect of those. Amanda, please can we have paragraph 46 on the screen, that's at page 12. So we have looked at this before, but this is the final part of your statement which records your reflections and at paragraph 46 you express that:

"It is essential for services to make sure that family members are aware of the care plan in place", and that a family support network is used.

A. Yes.

Q. As a tool to ensure a patient's safety. Beyond what you have said already, is there anything further you would like to add in relation to that?

A. Just to acknowledge the background of the patient as well because he was known to mental health services since 2000. There was no acknowledgment of that.

Q. Thank you. And so you are referring to the breakdowns that you have set out in your statement, and his diagnosis of endogenous depression.

A. Yes.

Q. And that, and if I understand it correctly, you feel that that wasn't something that from the records you have seen, that was understood or appreciated as part of --

A. That's correct, yes.

Q. -- the picture?

A. Yes.

Q. Thank you. Then at paragraph 47, you say that staff should be trained in how to appropriately talk to patients and their families, and again is there anything you would like to add in relation to that that we have not covered already?

A. It's just that, it's just the basic training, you shouldn't even really need training, but you know, showing empathy, the way you approach patients and their families, and just more understanding of the individual.

Q. Yes. And on the final page, if you turn over to page 13, you say that you:

"Do not want to see other families lose their

loved one in the way that I have lost my uncle, and I hope that the system can change so that patients are provided with adequate support and treatment in the future."

Is there anything further that you would wish to add at this point to what you have said already in your evidence?

A. No, I think that sort of summarises how I feel, yes.

MS LLOYD-OWEN: Thank you, Sam. I don't have any further questions for you at this stage. Chair, do you have any questions?

THE CHAIR: No.

MS LLOYD-OWEN: Amanda, can we please have the photograph of Keith on the screen? We will now show a photograph of your uncle Keith.

Sam, we will now have a ten minute break to see if there are any further questions. If there aren't any, that concludes your evidence and you will be free to leave. Thank you again for the evidence you have given today.

We will be returning at 2 pm, I understand.

THE CHAIR: Thank you very much indeed for coming and for giving us your evidence. I appreciate it.

THE WITNESS: Thank you.

(12.38 pm)

(Break)

HEARING MANAGER: There are no further questions for this witness so we will now break for lunch until 2 pm.

(12.46 pm)

(Luncheon adjournment)

(2.00 pm)

THE CHAIR: Ms Harris?

MS HARRIS: Good afternoon, Chair.

Chair, this afternoon we are going to hear from Sofia Dimoglou, who is going to give evidence about her mother Valery. May the witness be sworn, please.

SOFIA DIMOGLOU (affirmed)

Examination by MS HARRIS KC

Q. Can you please state your full name for the record?

A. Sofia Dimoglou.

Q. You have asked that during the course of your evidence I call you Sofia, are you happy with that? Sofia, you are here to tell us today about what happened to your mother, Valery Dimoglou. You made a statement about that and I think there in front of you, you have a copy of it; is that right?

A. Yes.

Q. If you go to the very last page, I think it is 59 pages long or thereabouts?

A. Yes.

Q. Do you see your signature underneath a declaration of truth, maybe on the page before?

A. Do you want me to sign it?

Q. No, just for you to identify your signature and the declaration of truth on the final page?

A. Is there a signature somewhere?

Q. Try the page before.

A. It says there is a signature but it just says "[I/S]".

Q. You are absolutely right. It is a redacted version of the statement. Do you see there is a redacted version of the statement with a declaration of truth?

A. Yes.

Q. It is dated 12 May 2025?

A. Yes.

Q. Do you still stand by the contents of the statement you made for this Inquiry?

A. I do.

Q. Can I just make clear for the record, all of that statement will be taken into account as your evidence about what happened to your mother, even if there are parts that we don't get to or read out this afternoon. Can I then turn please to your mother, Valery, who I think was also known as Val. You have indicated, I think, that you would like us to call her Val during the course of your giving evidence.

A. We called her Val, the children.

Q. You are one of Val's four children. You have an older brother Andrew, a younger sister Nicola and a younger brother Pablo.

A. Yes.

Q. Just really by way of background, Sofia, you have already given evidence to the Inquiry. You gave a very powerful commemorative statement about Val last September in Chelmsford. The Inquiry was very grateful to you for that account. You told us during the course of that account that you had a happy childhood. You are nodding, I may have to ask you occasionally to say "Yes", just for the transcript purposes. Thank you.

A. Sorry, yes.

Q. You were all very close to your mother.

A. Yes.

Q. And as we will hear in a moment, you were all involved in her care as far as you could be, in the period we are talking about?

A. Yes.

Q. I think, as a matter of fact, Nicola lived closer geographically.

A. Yes, in the same town.

Q. But that you would travel from where you lived to be part of that as well when you could.

A. Yes.

Q. I won't ask you to turn to it, but in paragraph 291 of this statement, you say some more beautiful words about your mother. You say she was:

"A girl full of dreams of seeing the world, a mother devoted to her family and determined to give all four of us - and our dog - the best of life ... We wanted her to know how much she had accomplished, and what a brilliant person she was, and we did our best to do this, right to the end."

A. Yes.

Q. And that's what you are going to tell us about this afternoon.

A. Okay.

Q. Val was born on 15 August 1939 and she died on 9 October 2015, at her home address.

A. Yes.

Q. And I think we can all have in mind that that was just over ten years ago last week. She was 76.

A. She was.

Q. And she had taken an overdose of medication and in circumstances we will come to in a moment, she was found by your sister.

A. She was.

Q. At the time she died, Val was an inpatient at the

Henneage Ward at the Kingswood Centre or Kingswood Medical Centre, often called different things in Colchester, and the Henneage Ward is an older adult in-patient ward.

A. Yes.

Q. Now given the dates it is perhaps right that we should make clear for the record that at the time your mother was an inpatient in the Henneage Ward, it was part of the North Essex Partnership University Foundation Trust, because we know, don't we, that after that time that trust merged with another to become EPUT.

A. It did.

Q. The admission that took place, or the admission of 2015, was Val's second admission to the Henneage Ward.

A. Yes.

Q. She had had two relatively lengthy periods of admission in the Henneage Ward, the first was between January 2014 and August 2014; is that right?

A. Yes.

Q. And then the second admission was from October 2014 to the time of her overdose and sad death in October 2015.

A. Yes.

Q. So it was almost a year to the day, I will come back to that in a moment. Now again, we will come on to the details in a moment, but just to summarise the position,

from about June/July 2015, when your mother was an inpatient on the Henneage Ward, there were discussions about discharging Val from that ward. I think there were discussions from earlier but they started building up in about June/July 2015; is that right?

A. Yes.

Q. This culminated in Val being seen by a ward manager on 6 October 2015; yes?

A. Yes.

Q. And then by her psychiatrist, who we will call Dr A for the purpose of the proceedings.

A. Right.

Q. On 7 October.

A. Mm hmm.

Q. And is this an accurate summary; she was extremely anxious about the prospect of being discharged from that ward.

A. Yes.

Q. And she was in that October time, and we will come to it in a bit, expressing suicidal ideation.

A. She was, yes.

Q. We will hear from you shortly that her observation levels had been increased.

A. Yes.

Q. And then were decreased shortly afterwards. On 9 October

she was granted a period of extended leave and during that leave she took the opportunity to return to her home address and take the overdose of which we have heard. Again you are nodding.

A. Sorry. Yes, she did.

Q. It is difficult and there I am speaking, but if you could say "Yes" for the transcript, that would be much appreciated. Now, the way I am going to ask you to approach your evidence is that we are going to go through, from just before that first admission, a chronology of what happened to Val. But before I ask you those details I am going to ask or outline with you, if I may, the concerns that you and your family have raised about Val's care and her treatment whilst an inpatient under the care of NEPT. I am going to ask you to do that so that we can all have them in our mind whilst you take us through the chronology in a moment. If I am summarising any of these inaccurately please stop me or correct me. In terms of the concerns expressed by you and your family, you are concerned that Val herself was not properly involved in the decision-making around her care and treatment.

A. Yes.

Q. You are concerned that her family, that being you and your siblings, were not involved in the decision-making

surrounding her care and treatment.

A. Correct.

Q. In addition, you would add that you were not given sufficient information about her treatment and what was happening to her generally on a day-to-day basis.

A. True, yes.

Q. You are concerned about how she was treated on the ward by certain members of staff.

A. Yes, definitely.

Q. And you are concerned generally, more generally, about the lack of compassion and dignity that was being afforded to the in-patients at this time.

A. Yes.

Q. Later on you consider that Val was pressured, or bullied even, towards discharge.

A. Definitely.

Q. You also consider that there were safety and/or safeguarding issues on the ward.

A. Definitely.

Q. And you are concerned that there was no awareness, or a lack of awareness, around the need to keep voluntary patients just as safe, if I can put it that way, as involuntary patients.

A. Yes.

Q. You are concerned about the adequacy of some of the

assessments that were undertaken in relation to your mother across the period.

A. Yes.

Q. You are concerned as to Val's diagnosis, or lack of settled diagnosis I think you would say.

A. Yes.

Q. You are concerned about the medication that she was receiving, or the lack of apparent strategy to that medication.

A. Yes.

Q. You are very concerned about the care plans, or the lack of quality of the care plans, or the lack of care plans sometimes at all --

A. Yes.

Q. -- or apparent lack. You have expressed grave concerns in your statement around the arrangements, or the lack of arrangements, towards Val's discharge, which were ongoing.

A. Yes.

Q. And you are concerned about the arrangements or lack of arrangements as you perceive them, for giving or granting Val leave from the ward and, in particular, on 9 October 2015.

A. Yes.

Q. And to conclude, you are deeply distressed and concerned

by the behaviour and the attitude of the Trust after Val had died.

A. Definitely.

Q. And can I break that into three main parts, really, and we will come back to it in your evidence. You are concerned about the nature of the serious incident investigation and the circumstances in what I might call the more immediate aftermath. You are concerned about the behaviour at the inquest of the Trust.

A. Yes.

Q. And you are concerned about what you see to have been continuing defensive behaviour, which took place in a meeting that we will come to, some three years or so later.

A. Yes.

Q. All right. Can I take you back a little bit, if I may, to help us with some of the chronology in that period leading up to Val's death. Now, the way I am going to do it is I am going to tell you where the various parts are in your statement. You can go to them, you can expand on them and we will do it in that way. It may mean we will jump around a little bit in order to pull it together for a chronology, but let's see how we go. You explain, and I am just going to deal with background, if I may, for a moment, and for your reference and for anybody following

by the way of statement, this is paragraph 13. You explain at paragraph 13 of your statement that Val had been under the care of a psychiatrist that we are calling Dr A since about 2009. Is that right?

A. Yes.

Q. And I think you make the point there, and you stress it several times in your statement, and I think it helps us get the measure of Val as a person, that she was over-deferential -- I think those are the words you use --

A. Yes.

Q. -- to doctors particularly in the early days.

A. I'm just going to move my chairs if I may.

Q. Are you okay? Sorry I was asking you about being over-deferential to doctors?

A. Yes, she thought that they were always right.

Q. And you pinpoint, I think, mid-2013 as the time that you describe, and this is for anybody following paragraph 15, as a crisis point in her mental health?

A. Yeah, when she just wasn't herself at all. She couldn't really function day-to-day properly.

Q. There is a later report, I think when she sees a psychologist, we will come back to that again in a moment, where she describes I think having been lying under a blanket for six weeks around that time, only

getting up to take the dog out, for example. Is that the kind of presentation?

A. I mean I would go and see her because I lived away, but she was just shaking all the time and really distressed and it was about that time I went to the doctor's and tried to insist that I talk to a doctor on her behalf because it was just ongoing and it was a real crisis.

Q. And I think you did talk to a doctor and as a result of your efforts, ultimately, Dr A, the psychiatrist that we know under whose care she was, referred Val to a psychologist for some Talking Therapies.

A. I didn't talk to a doctor, they wouldn't talk to me, I talked to a receptionist.

Q. Sorry, I meant you went to the surgery to try and chivvy up this referral. We will call the psychologist, psychologist B for the same reasons we are calling Dr A, Dr A. But I think it is right that Val was waiting or had been waiting for that referral for some time.

A. Yes, months.

Q. You mention in your statement that in the past, and we don't need to go to it specifically, that Val did have experience for example of cognitive behavioural therapies and those kind of therapies?

A. Yes, they worked for her. They helped her a lot.

Q. But as you say, she waited for a long time, you chased it

up and she first saw the psychologist, I think, on 6 December 2013?

A. I think at least six months.

Q. One of the things that you say with hindsight is unfortunate about that appointment is that the psychologist had a trainee, as often is the case, with her on that day. Why do you think that was unfortunate?

A. Well, Val couldn't really cope with lots -- she's quite private, so she didn't want to tell people how she was feeling and she was absolutely desperate. We didn't know quite how bad she was because she didn't want to tell us everything, so she really wanted to be able to tell one person. And also because she had a little bit of a fear of authority, I think, if someone was in there taking notes, then she didn't know exactly what was going to happen with those notes. Whether or not they explained it to her, she still found it uncomfortable. Also I don't know how young the trainee was, but my mum probably did feel a little bit like she wanted to tell the professional, not somebody who was training, but she wasn't confident enough when she was asked, "Do you mind" she wasn't confident enough, like a lot of us aren't, to say, "No, I don't want them in here." So she definitely told us that she didn't speak openly at that meeting.

Q. That was the initial meeting with the psychologist?

A. She said she didn't speak openly, but I do remember from the notes it did say that Val was a high risk of suicide at that time, so that did come out in the meeting.

Q. And I think it came out, as you say, there was discussion around suicidal ideation in that meeting with the psychologist.

A. Yes.

Q. We remind ourselves that was 6 December 2013. On 7 December there was an accident, Val crashed her car.

A. She did.

Q. And that was a deliberate crash.

A. Yes, into a moving lorry.

Q. And as a result of that and just for, again, the record and those following, this is paragraph 20 of your statement, she sustained serious injuries, I think burns, fractured hip and significantly, one of her much loved dogs didn't survive that accident.

A. That is true. There was also a BBC crew following the car, just by chance, and they filmed what happened which is probably still on the internet. So that was on the internet almost instantly because it was on the news. So they didn't film the crash, they filmed her being treated at the side of the road.

Q. The aftermath. She was, as you say very badly hurt, but survived that crash and after treatment for her physical

injuries, she was ultimately admitted to the Henneage Ward on 8 January 2014. Does that sound right?

A. Yes.

Q. I think to be fair, you had to chase that up, you had to engage Dr A to become involved --

A. Without going into loads of detail the physical injuries were profound, burns, the car set on fire, so she was really badly burned, broke her hip so loads of stuff had gone wrong, dog was dead. So the psychological stuff deepened, like it became absolutely intense. Not one person in one of the hospitals dealt with the psychological. She was in three different hospitals. So nobody talked about the psychological stuff. When she eventually got moved to Colchester General, they put her in a room on her own, which was absolutely not the best thing to do for her. So the bit when she was on her own, it was really dangerous. And then I eventually, I was like, why hasn't Dr A been in touch? I knew where he was, he was literally 100 yards away or something, I don't get it. So I kept ringing his office. They just kept saying he can't talk and that's when I said, "I'm definitely going to put in a complaint", and then he turned up.

Q. And ultimately, sorry to cut across you, but ultimately then she was admitted to the Henneage Ward --

A. Yes, so he came to the hospital and saw her in person, and was kind then, and I think he saw that maybe as a way to help her through the next stage was to put her into this ward and it was all on his doing. I mean, he had the power to find her a place, so that's when she went into there.

Q. Once she was on the ward, I think it's also right, and you deal with this at your paragraph 32, that she was seen again by the psychologist, by Psychologist B, as we have been calling the psychologist, and the next appointment was 16 January where Val described feeling in agony and how she regretted surviving her suicide attempt.

A. Yeah.

Q. And at that stage, even at that stage, she raised fears about not wanting to go back to her home?

A. No, she was terrified about going back.

Q. You tell us in your statement at paragraph 33 that overall, Val had 45 sessions of therapy with the psychologist, does that sound right?

A. I think that was what was in the records.

Q. You also explain in your statement, again for the record this is your paragraph 75, that during the course of this first admission, Val felt she could be sent home at any time. She was worried she would be sent home at any time

without planning or discussion with her and her family.

A. Yeah, most of the -- all of the hospital moves had happened really suddenly, sometimes like really late at night, and it was just suddenly like, "That's it now you are moving to this place or now you are moving to that place." So she thought that that was the style and that was what was going to happen next, that the next thing would be, "You are just going to go home."

Q. Can I just clarify that with you, from the hospital moves you mean when she was being treated for her physical injuries?

A. From Addenbrooke's -- the first one was Ipswich. When there was an emergency they took her to Addenbrooke's, Cambridge and then the Addenbrooke's move happened Christmas Eve, but really suddenly she got taken to Colchester. Then the move from Colchester into the Henneage Ward, again she was told at 9 o'clock at night or something, it was really late. Then she basically had to walk across the carpark to the next place.

Q. I think your brother came at short notice to help with that. Is that right?

A. My brother came.

Q. So that was in terms her first admission, and she was discharged from that first admission in the August, August 2014.

A. Yes.

Q. How did that come about?

A. I think there had been talk about how she couldn't stay there, and that she was presenting a little better, and she was taking kind of issue with how much medication she was being given, and she decided that she wanted to try and live without, like, so much medication and that wasn't really the style. So she kind of felt that it was time for her to do something for herself, rather than -- because she just sort of felt that she was just turning into a kind of a medicated person in the Henneage Ward, and she was also worried because they had been saying to her, "You can't stay here." So she, I think I'm pretty sure she discharged herself at that point.

Q. Can I just ask you about what is a short intervening period, because we know she goes back into the Henneage Ward in the October of 2014. She was discharged, or she left the ward, and she had the support of the home treatment team, that was the plan, and the community team. August to October, just thinking back, can I ask you how was Val in that intervening period, to begin with when she came out?

A. There were moments that she was brilliant. She did her garden. She didn't, she couldn't have, she had two dogs, one of them survived. She didn't feel that she could

have the other dog back, that was too stressful for her. She did feel a lot -- she would go up and down, so she would feel a lot of guilt about being in the house because obviously that's where she made the decision to get into her car and take the dogs with her. So that was really hard for her. She had little things, like she had a cleaner came who was from Brazil, I think, and was really lively and brilliant person, and my mum really liked people around that didn't know all of the horrible stuff. So she was really good for my mum, but she left in October. She went, either got -- she left town altogether. That was quite hard for Val. And she also like, I have got a cousin and the cousin visited her, so that was my mum's sister's daughter, the sister that died on the same day that she died basically. She went to visit her, and I remember Val saying it was like a breath of fresh air to have my cousin there. So there were moments like that, that felt really positive, and she definitely was not in the same fog of medication.

Q. Can I ask you about that, sorry to interrupt you, because you did talk about the fact she didn't want to be medicated and you though she wanted to do something for herself and come off the medication. So far as you are aware, and I am talking about this period August to October 2014, did your mother -- did Val come off any of

the medication?

A. As far as I am aware, she did come off everything.

Q. Do you think that was managed or done herself?

A. You mentioned the home treatment team, they were just a nonentity to us, and Val didn't, she didn't engage with them, she didn't like them individually, like they hadn't really made a lot of effort to be trusted by her, if you see what I'm saying. She didn't really like people in her house anyway. I had met -- I can't even remember the dates fully, but I had met one of them who was quite offhand and I hadn't met her formally, I just bumped into her. So there was a lot of kind of strangeness about what is this care in the community situation. So I wouldn't say that they were assisting. They were, I think there was occasionally they would call her or try and arrange to go round, but she would try and keep them on the doorstep. I think once they went in and the record of that, I remember reading, was not very nice. They said something about her house not being clean, which I thought you know the house was fine. Cleaner than mine. So it did feel like I thought she was coping really well, but the home treatment team seemed as if they just had some standard things that they would say, and the medication it felt like she had stopped but she didn't -- she didn't really talk about it. It definitely

wasn't a managed stop.

Q. Can I just take you back again to that intervening period, because we know, and we will come on to it in a moment, that she went back into Henneage Ward on 10 October, and she was seen by Dr A again on the 7th. There had been, by 7 October, a decline which we will come on to. There was another trigger, I think, in the intervening period. Did your mum receive a letter that caused her great upset?

A. Yes, so she had a letter from the RAC who were insurance company, and basically they had said that they were going to charge her something like £5,000 because of the crash and they had already dealt with the insurance, everything had all been dealt with. So it all finished, and then it just came up again, and she was devastated about that. Obviously it triggered her for the memory, but also she couldn't afford the payment. I think my sister rang the insurance company and said, "What are you doing" and they just said, "Sorry it was a mistake." So the letter was actually a mistake. They didn't want to claim any money back off her, but it sent her spinning, really.

Q. At paragraph 35 of your statement, again I say for the record, you talk about how in correspondence, Dr A makes reference to Val's decline following the demand for a significant sum of money.

A. Right, yes.

Q. So mistake or not the effect had taken place, as you say, on Val. Can I then ask you about the assessment on 7 October 2014 with Dr A. As part of that, again, I will remind you what's in your statement. Please feel free to go to it if you want to. Dr A, I think you say in your statement, noted that Val had already had a protracted admission to the Henneage Ward, which was the January to the August, and he, himself, stated that she didn't seem to have been making progress on antidepressants.

A. That she didn't?

Q. That she didn't seem to be making progress on the antidepressants.

A. A number of times it was pointed out that she was still suicidal and that the antidepressants weren't changing the fact that she felt suicidal.

Q. We will come back to the medication in a moment, because your concern was that they were exacerbating that in fact.

A. Yes.

Q. But just talking in terms of Val's going back into the Henneage Ward, you also explain in your statement at paragraph 78 that since that time you have seen Val's inpatient care plan, which shed some further light on to why she was readmitted, or Dr A suggests she be

readmitted, and that the notes say she had been doing well with home support from her care co-ordinator, her mood deteriorated, experienced high levels of anxiety and there was concern that Val had missed appointments, one with the home treatment, one with the care co-ordinator and there was concern she was disengaging with the service, which is consistent with the observation you just made that she didn't seem to want to have much to do with them and wanted to keep them on the doorstep.

A. Definitely, yes.

Q. Later you say the family weren't involved, and I think you said you only met one once, and that was by accident or by chance?

A. Yes. There was absolutely no liaising with us about the best way to help her at home.

Q. I think you have already referred to the fact that the notes you saw were a bit blunt, and not very kind, and you made reference to the house and the cleanliness of the house.

A. Yes.

Q. Did you have concerns then about the level of engagement from the care coordinator about how this was all being organised?

A. Yes, totally. I did have one person's number, but they never contacted me and if I tried to contact them, I

would normally just get like a voicemail or something. So there was no, "This is how Val is feeling, what can we do to help her?" They were doing something in the background. Val was pretty much trying to avoid them, I think, and then obviously it all came to a head with the letter.

Q. I just want to jump ahead a little bit in your statement because, of course, this is Val's experience of discharge we are dealing with now, and it is obviously relevant when we come to later on. In your statement at paragraph 243 you make reference to Val, you say, feeling unsupported, misunderstood and even bullied by the community team.

A. Yes, one of the community nurses was a man and she found him quite intimidating and quite unpleasant. Again, I saw him once in a room with lots of other people but he never introduced himself to me or -- it just feels for me like your elderly parent, they are trying to help her get back into the community, talk to us, meet with us, arrange a meeting with Val there and talk about what's happening, rather than this all somehow happening in the distance. I know I lived away, but my sister was local, she could have got involved as well.

Q. I think again, at paragraph 244, you say and of course we bear in mind this is your experience of, if you like,

life post-discharge, that there was no continuity and no oversight, that was your sense?

A. Yes, definitely.

Q. Can I, just before we deal with what is Val's second admission, and just keeping with the chronology, it's right I think that you wanted a second opinion in relation to Val's mental health.

A. Yes. So obviously our whole life we had known that she had sort of mental health issues, she had had really bad PMT as I was growing up, so there were definitely things that we knew. There was never one diagnosis, there was always various things and I think I listed them in my statement, like depressive disorder. Someone had written "borderline personality disorder", and I was like, what does that even mean. I had obviously thought could she be bipolar because she was really happy and then really down. Nobody really just seemed interested. It was almost like they just said she's got some kind of depression. We can't really diagnosis it. There was never a proper diagnosis.

Q. Just fitting this then into the chronology, we know that Val saw Dr A on 7 October, and as it happens the second opinion from Dr C was following an assessment on 8 October, so very close in time together. You went to that assessment, and I think the issues listed to be

discussed were, as you say, potential for bipolar disorder because that was something you were concerned about, her risk of suicide, and also I think lithium treatment or other medication was also discussed.

A. Yes, just what is the medication? If she did have a diagnosis of bipolar, what would the medication be? Would it be a different course of treatment to the kind of quite ad hoc antidepressants that was going on? Is there a more kind of defined strategy if you've got that diagnosis, to a different one? Could there be a misdiagnosis? What's going on?

Q. And just to summarise, then, the second opinion you got from Dr C, he noted that she had depression, he noted that there were indications of mood instability including some hyper manic features, but he didn't consider that the diagnosis of bipolar disorder was warranted.

A. No, he said no.

Q. He considered, and noted that the antidepressants had had mixed results.

A. Yes.

Q. Which is how you described it, and discussed lithium with Val, lithium being a mood stabiliser, as you have identified, sometimes prescribed to those with bipolar disorder. But Val declined lithium at that stage in the October.

A. She didn't really want any more drugs and she didn't want anything that sounded a bit scary, which lithium does. So she just didn't want any more of anything. She just wanted to feel that she was safe.

Q. And Dr C recommended ongoing monitoring and psychological support to help manage what you have stated in your statement he described as Val's moderate to high suicide risk.

A. Moderate to high, yes.

Q. And I think you also explain in your statement that Val was keen to transfer her care to Dr C.

A. I wouldn't say "keen".

Q. Sorry, that is my word.

A. No, it's okay. She wasn't really keen. I mean the way she expressed it because obviously she felt she didn't want to get on the bad side of Dr A, because she felt that he was the one in control, which he did seem to be. So she was, again, like really apologetic and I think we wrote a letter. She wrote a letter saying, "It's not because of you. I just want to try and move on from everything that's happened and it might give me a fresh start." So she actually did express that and thanked him for what he had done.

Q. Was there a transfer as such?

A. It was just a mess to be honest. I don't feel that Dr C

even wanted to take my mum on. I had high hopes that it was going to be a different approach, but he just seemed like another version of the other person. They just were really cold, and when I was asking questions or saying something, they just looked at me as if to say, "Who are you and what do you know? We're the experts." So I was really disappointed because I just felt like there was just a disinterest if I'm honest. That's what it amounted to, just didn't feel like -- it just didn't feel like they were really trying to investigate who she was and how they could treat her.

THE CHAIR: That's the same for Dr A and Dr C?

A. It was, yes. There was maybe a ten minutes in one of the assessments, they were both quite good at being softly spoken and expressing like kind sentiments, but then the medication would be ramped up, or it would just feel like we had gone into the same void we were in before.

MS HARRIS: Can I just pick up on something you said about diagnosis because we outlined at the outset that that was one of your concerns, was that you just felt that nobody got to the bottom of what the correct diagnosis was, and you have already said how it was given various names, depression, depressive disorder, there was acknowledgment of the up and down moods, sorry that's me summarising, and the reference, as you have already said, to

borderline personality disorder. You have just said in your evidence, "What does that even mean or what even is that?" Can I just pick up on that, did anybody take time, do you feel, to explain the differences between these potential diagnoses?

A. No, no one even talked to us. They didn't talk to us about anything. Even if I pressed them in a room when I had them there, which was very rare, they would just say it is depression and that's kind of like a broad spectrum of things. Obviously, I didn't like that sound of borderline personal disorder. I was like, "That makes her sound like she's psychotic, what does that even mean?" They said, "Now we are calling it this", so it just felt like it just shifted.

Q. Can I then move us to when she is readmitted to Henneage Ward, which you have said is the 10 October. Now just to be clear for the record and I am looking at your paragraph 79 again for those who are following it. She was reluctant to be readmitted but she did agree to be readmitted. Have I summarised that correctly?

A. Yeah, I mean, the thing is, a lot of things we have talked about, you know, even like moving from one hospital to another, every single thing was massively traumatic, so none of this was over, then she was admitted. Every single time she went anywhere it was

huge. I got a phone call at work, teaching in Sussex, that my mum had been asking the neighbour for pills because the neighbour was a nurse. So that neighbour rang me, I don't think she could get my sister, so I literally left work, I don't think I got someone to look after my daughter, I think I just went straight away. So when I got there the kind of medical team had turned up, the neighbour was out, my mum was on the door, it was all nightmarish and it was basically either you are going to be sectioned or you are going to come voluntarily. So it was that kind of thing and my mum was really distressed but sort of said, "Well I don't have any choice, do I?" She didn't want to go and it was like, well, you have been talking about you actively trying to kill yourself.

THE CHAIR: I think you say in your statement she had asked the neighbour if she knew the best way, or something of that nature.

A. Yes, if she knew the best way and sort of suggested that she might be able to get her some tablets. Can I just say as well that to me -- because it isn't that difficult to go to a number of chemists and buy whatever, to then take a load of pills, you can do it. I know you can't buy them all in one but ... I think to me it was another indication that Val didn't really want to kill herself, she really wanted someone to help her. Because she was,

she knew enough that she could have done something. So she was talking about it rather than doing it. Which again to me made it feel like she just didn't want to really kill herself at that point.

MS HARRIS: Hence the engagement of the neighbour on that particular occasion.

A. Yes.

Q. One of the concerns you raised and you have just touched on it in your statement, is whether Val should have been sectioned when she was admitted to hospital, and we have already heard that there was discussion about whether she should be sectioned but she agreed to go and was in effect compliant. You also observe, however, that she was very fearful of being sectioned.

A. Well, being sectioned always meant, historically, it felt like that meant you were going to get the electric shock treatment. I mean, it felt like for her that would mean the white coat and the tie me down. She felt that being sectioned was really like a hefty kind of thing and again no one really talked about what the difference was. Even to me they didn't really talk about it and I had done a little bit of research at that point. In terms of my own -- I didn't know, I really didn't know. I thought the experts would talk to us about what it meant. I just felt like she had to be protected from herself and -- and

also the general public had to be protected because obviously she had driven into a lorry. That's quite intense to be that bad, to feel that mentally unwell that that's something you would do, put other people at risk. So it felt like whatever it needed to be, but we didn't really know what it meant either. Also, we had grown up not trying to thwart what my mum wanted, so she had a bit of a saying, "Don't tell me what to do." So that was a moment, that's like the worst thing you can do is say, "Right, we're saying we want you to be sectioned", so we just kind of let the process happen. And she did go in.

Q. She went in, as you say voluntarily, but you refer in your statement to being concerned that perhaps, as you say, she should have been sectioned but nobody really talked to you about what that would mean or why that hadn't happened or ...

A. I still don't know. Yeah, I still don't know why that wasn't a discussion and an option.

Q. One of the concerns that you have outlined in your statement in several places is that you were concerned that if she had been sectioned, if she had been an involuntary patient, you think that may have changed the way she was looked after or kept safe.

A. Well, it's really -- it is quite interesting because I just had the thought now that if she'd have been

sectioned, they would have had to do observations on her. And it's a little bit odd that she's asking a neighbour basically to help her find a way to kill herself, but then she's not put on observations because she is just taken in at that point and I don't think that she was put on the 15 minute observations. But also from the point of view of us, like anyone who has ever lived with suicidal loved ones, you are constantly worried that you might say something that might trigger suicide. So you don't want to be the person that says, "Val you need to be sectioned for your own safety", because that might have made her more determined to end her life. So it was quite a balancing act.

Q. Can I just turn to when she then gets to the ward? This is a slightly separate topic that you have dealt with in your statement and it's about safety and safeguarding on the ward when she gets there, because one of the things that you are concerned about, and you make reference, is as you say whether or not it would have been different, certainly in the early part if she had been sectioned. You acknowledge, I think, or you say in your statement that Val had concerns sometimes about safety on the ward, for example in relation to the mixed gender toilets. Was that something she was worried about?

A. Yes, she didn't like that. I mean, there were men and

women on the ward and she didn't like the fact that the men could wander about, I think like a couple of times someone had walked into her room.

Q. I think another cause for concern was that Val's room, you tell us in your statement, was on the ground floor and next to a very busy road.

A. Yes.

Q. And that in August 2015, somebody climbed through he window and stole her bag, which had money in it.

A. They did. She wasn't in the room but when she went back in, her bag had been stolen from the room. She had locked it from the outside so ...

Q. Sorry, when you say she locked it she had locked the room --

A. I think she had locked the room from the outside.

Q. The door to the room, you mean?

A. Yeah or some -- she knew it had been done from inside because the window was open. She always had the windows open a bit but she didn't realise that one of the windows was broken.

Q. I was going to come on to that because someone, I think, was eventually caught and prosecuted for that theft; is that right?

A. Yes.

Q. And it turned out that the window in the room was -- so

the window of this ground floor room was faulty which meant someone could come in.

A. Yes, it was a faulty window and people could get in. It was very close to the main road.

Q. Can I just ask you this, were you or your brother or your sister, or any of your family, told that somebody had climbed into your mother's room and stolen her handbag?

A. No, we weren't told anything. We weren't contacted in any way and we only found out because my sister went to pick my mum up, my mum had actually started meeting us outside the ward for I'm not entirely sure why.

Q. I am going to come to that in a moment.

A. There was some weirdness going on at this point where we had been very much inside the ward; even my daughter, who was kind of not legally allowed in, came in at first. So it was almost like a little family to go and see Val, and then we sort of felt like we weren't welcome on the ward but Val also seemed to keep us out. But my sister did go inside because she realised that Val was really distressed and it was only when she was saying what's happened that Val seems really distressed, that then they said there had been a burglary. But that had been like a number of days before.

Q. You have, I think, seen medical notes since which refer to this being discussed with Val by the, I think the

clinical manager or the matron, and you noted that during the course of the conversation about the bag having been stolen and the open window, that that formed part of a conversation about how Val's house hunting was going?

A. So Val had started telling us around this point that she was being bullied by the ward manager and what are we calling them, matron?

Q. The matron.

A. Clinical manager. So we didn't not believe her, but obviously she was highly medicated and I wouldn't say paranoid, but when people are like on drugs they often do present as a little bit paranoid --

Q. So you were treating with caution what she was saying.

A. Yes, so we were trying to monitor it but again we weren't, not that we weren't allowed in but when we were in we weren't having the conversations that we used to have. We used to go into the office and have a conversation what's been going on, how things are. That all stopped, so they were keeping us at arm's length as well. So we didn't really see them. I have lost my thread, what was the question?

Q. I was asking you if you had since seen some medical notes which suggested to you that this had formed part of a conversation with your mother at which point she had been asked how her house hunting was going?

A. Yeah, so we -- my sister and I especially were talking about what do you think is going on and we had said that one of them we did feel uneasy about and we were trying to monitor it but it was hard. And so it wasn't until after Val died that we saw the medical notes which also took months for them to get to us, that was another layer of stress. And when we got those medical notes, that one in particular, we were just, "Well I cannot believe it." So the medical note for that conversation between the matron or the clinical manager and Val was her -- the police had been, obviously, the police had been called to the hospital, was her -- and all this had happened without us knowing about it. As I said the police had been called and then they were talking to her after it, and she had actually recorded what she had said and she put on it that, "I had the conversation about what the police had said and then I took the opportunity" -- I am sure she used those words -- "to ask Val about her discharge plans", and I was really stunned. Because that did amount to "When are you leaving?" Almost as if to say, not as if, you know as if the bit between the lines is "Well it's not really safe, is it, because someone's climbed into your room. When are you going somewhere else?" Rather than "How awful, we are really sorry, that's something that we have got to deal with." So

yeah, that was the push. That was the push, every single thing that ever happened after that, that we saw in the notes.

Q. Just on the safety point for a moment, and we will come back to those other parts of the notes you have seen, you were also concerned for the record that she was as a voluntary patient, she was allowed to take things back onto the ward, and I think you list her having cans and tins and knives and bleach, all of which were --

A. Yes, so Val, she didn't really like their food that much but she did like food still and she had loads of tinned fish. And those, you pull the thing back, don't you, and they're really, really sharp the edges. So she had -- I mean, she must have had like ten tins of fish in her wardrobe and she did, I said, "Has no one said anything?" And I think she said that someone had joked about it once, one of the staff members. So they definitely knew that that was happening, you would know it was happening because the room absolutely stank of fish or bleach and she had the bleach thing under the sink because she would do her own -- she would like bleach things. And she would do her own washing in the sink so she used bleach a lot.

THE CHAIR: Was that in her own room?

A. In her room.

THE CHAIR: Yes.

A. But the staff obviously would go in there, well, and as I pointed out the door wasn't always locked, other people could get into that room as well, whether it was from the door or the window. So I was shocked but at that point we felt that Val was kind of getting on okay, she was finding the ward quite interesting and so reporting your own mum for taking in a knife and some tins of fish didn't seem like a good idea.

THE CHAIR: I think in your statement you suggest that she liked being self-sufficient and she enjoyed, you have just said, getting food for herself. What would have been her reaction, do you think, if anybody had tried to stop her from having tinned fish and bleaching?

A. I mean, she would have been depressed. She would have been really depressed because she was always like scared of authority but did break the rules. She quite, I think she quite liked breaking the rules, so she probably would have felt a bit like I have been caught I will have to stop now. And maybe she would have, I don't know, that was at a time when she was really avoiding going to her own house at all. So the fact that she felt like her room for a couple of months was her home, it did feel like it was for a little while, that that kept her quite stable. So if that had been taken away, I think it would

have sent her into that kind of instability again.

THE CHAIR: Thank you.

MS HARRIS: Can I just pick up on that? Thank you, Chair. Because returning to the chronology now and picking up on the question that Chair has asked you, we do see, don't we, from your statement, for example your paragraph, I think 105 and 22 just for those that are following, that you consider that Val did make progress while she was on that ward. You were just talking about how she had become stable and her room had become her home, and you think, I think you say at 105, that you feel her recovery was assisted on the ward.

A. Yes, there were certain months, not the very beginning which was quite dark, but then she did, she engaged in some of the sort of social things or there was one woman who did ... they would talk about the news, what was in the news and Val was really interested in reading newspapers so she really engaged with that. Val also loved playing scrabble and she would get the other people, it was almost like Val was working there at one point because she had always wanted to do sort of voluntary work. So for a few months it felt like Val was a sort of a helper and she even talked about, well we sort of talked about it with her as well about if she went out maybe she could do some sort of outreach work

with people because she really liked helping people. And food was a really big thing for her so she, I remember once I went and she wanted me to get her some fish and chips and I went but she got me to buy somebody else some chips, somebody asked, "Could I have some chips?" So I think I was allowed to take them in but when I gave them to the other woman the ward staff went bonkers at me saying, "You can't bring food for other people", which I think Val thought was quite funny that we tried it but it didn't work. So she was always looking at what the systems were, she was very interested in what went on. So for a while she made some friends. She was really kind to quite a lot of people and the people who were more vulnerable than her, I would say, at that point, who didn't have visitors, for example, she really worked a lot with them and got them to play scrabble. Then once when she was playing scrabble I noticed that she was letting them win, she was like trying to build them up doing little nice things.

Q. In fact, and I am just moving on now to paragraph 47 of your statement, when you come to dealing with some of the later events in summer 2015, and I am talking now when she was assessed in the August but not accepted, in fact, for a place on a rehabilitation and recovery ward, do you remember at Ipswich road?

A. Yes.

Q. One of the things that was particularly noted, and partly why she didn't perhaps get the place but we will come to it in a moment, is that Val herself acknowledged that the ward had helped her manage her mental health and reported some mood stability. That came out later on. And that it was noted that whilst she had a past history of suicidal ideation and emotional dysregulation, at that stage, which is I think the period you are talking about, she was denying current risk and said that, you know, it was noted that she "was engaging in community leave and social activities", such that they considered her mental state was "stable, cooperative and forward looking". Was that a feature of that particular period would you say?

A. It definitely was. I mean the lithium did have a big effect because when she took the lithium she started getting hand tremors and couldn't write any more. The fact that she lost some of her personality through not being able to do things did make it worse for her.

Q. Can I ask you about the lithium, because we heard from your earlier evidence that she declined to take that in the October when you saw Dr C. When did she start on lithium to your knowledge?

A. Straight after that, straight after she said no they put her on it, but we didn't know this till we saw the notes.

So a lot of the medication we had no idea what she was being given until we got the medical notes after she died.

Q. On 1 April 2015, so we certainly know it is before then, she went and had another assessment with Dr A, this is your paragraph 43, where there is reference to her feeling anxious, to the fact that the venlafaxine was making her feel anxious at that stage, and as you say the lithium was causing her to tremor and making it difficult to write. She had been doing a writing activity, I think, hadn't she prior to that?

A. She had, yes.

Q. So that was affecting that; is that right?

A. Yes, yes.

Q. And you know from the 1 April assessment that the plan was that the ward manager was going to refer Val to the non, I think, non-psychosis pathway. Just dealing with the medication again, I think it's quite clear, you have said on several occasions in your statement, you take the view, your view is that she wouldn't have crashed the car if she hadn't been on the medication, I think the venlafaxine and the zopiclone at that stage. And you consider, as her daughter, that the medication was exacerbating her feelings of anxiety.

A. Yes, obviously I had known her all my life and she had

been on medication while I had known her but my mum was really anti-drugs, she hardly ever took like a paracetamol or anything, very against recreational drugs, didn't drink alcohol apart from a little bit at Christmas. So she was someone that drugs were going to have a massive impact on. So I could see that she was not herself so that summer before she crashed the car, when she was in a terrible state, we had been on holiday, she couldn't function, she couldn't function at all and she wasn't sleeping, which obviously is awful for anyone. So the zopiclone and the venlafaxine together was clearly having an impact on her, and it was only after the crash that she told me that every morning she would have suicide ideation, and she had to get past like 11 o'clock in the morning and then it would subside but it had been happening for some time that she just had this weird reaction. And when you read the side effects on most drugs but especially ironically the ones that are for lack of sleep or depression, one side effect is suicide ideation. And the suicide ideation is just two words, isn't it, but it massively means you are planning a way to kill yourself. That was what she was doing and obviously crashing your car into a lorry, not a great way to kill yourself for so many reasons. And so I know Val well enough that had that not been kind of drug-induced

suicide ideation, she would have had a plan that she would have done it at home and she would have worked it all out that the dogs were okay. She would have worked something out. And we had talked about suicide over the years, we talked about everything, and it had never been that she would just do something like jump off a cliff. We went to Beachy Head together and we were talking about Beachy Head as kind of a place that people went, and it was like, no, doing something that's going to create mayhem for loads of other people just wasn't something she had ever talked about. And it just -- I just know instinctively that that crash, because I saw her hours after it happened, and she was just -- I know she had had more medication then because of the pain relief -- but she just was talking absolute nonsense and I had never seen her like that before. And she had got in her head that I had come, because I was in town at that time, she had got in her head that I was coming to give her a car or do something like that she didn't want me to do. So she was just going round and round, she was just spinning with all the medication and probably having had the counselling the day before had not kind of helped her.

Q. One of the features of your statement is, and you say it a number of times, is as you have said your concerns about the medication and what you describe as

overprescribing, but in particular you say that you felt no one listened to you as regards her medication.

A. I mean, they literally looked at me like I was some kind of, I don't know -- right from the start, because when she was in Cambridge she was being heavily medicated for the physical injuries and I talked to the team then and said, "Isn't this a good time to get her off the venlafaxine and the zopiclone, which she believes made her crash the car? You need to get her off these", and they were like, "Oh no, we can't just take her off them." I mean, she was having all kinds of other medication and operations and anaesthetics and everything. She had a skin graft for the burns, she was in agony, physical agony. So they just said, "No, we are just going to leave the medication as it is." And then, I don't know if you were about to come to this anyway, but she wrote a statement, she wrote down that she did not want ever to have venlafaxine again and signed that and said that she wanted any medication changes to come through us, the children, and that document that we did see, which I'm not very good at keeping records myself, I don't think I had a copy of it, but that was in her records, didn't turn up in the records. So when we got all the records that wasn't there.

Q. You are right, that's exactly what I was going to come on

to because one of the concerns you have raised which we outlined at the outset of your evidence is this concern about the lack of involvement of, not only of Val, but of you and your siblings in decision-making and I was going to ask you because at paragraph 44, you say or you go on to say that you and Val all felt out of discussions, and I am talking more generally here, not just medication, and you say that she had made absolutely clear by way of written document that she wanted you to be involved, but yet you feel that you were shut out of discussions not just about medication, but more generally.

A. Yeah, everything. I mean, the medication thing, without telling us "Mind your own business we're the experts", that is kind of what they did. They not only ignored the fact that we said no venlafaxine in any circumstances, they carried on doing it. The lithium, same thing, why was she given lithium if she wasn't bipolar? What was the reason? I can't see any reason at all why she was given it and that caused the hand tremor. Just to point out, we didn't know that they had put her back on venlafaxine. We wouldn't have known until we got the medical records and especially the toxicologist's records.

Q. I was going to ask you, so you discovered that after she died?

A. Yes.

Q. Just in terms of communication with you and your brother and sister, you say that it had been recorded that she should discuss her care and treatment with all of you; is that right?

A. Yes, with all of us or any one or two of us. We didn't all have to be there. But not one of us ever got talked to about any of it.

Q. I was going to ask, you may not be able to help us, whether it was one of you in particular that was listed, for example, as her nearest relative or next of kin?

A. I think I was the person who was the kind of named person for the medical issues.

Q. Right.

A. My sister, Nicola, was the one who was there for the kind of immediate emergency because she lived nearby. One of the brothers lived in Norwich, so it was quite far away. The other brother is lovely, a bit of a hippy, not that much use. So he was there for visiting, brilliant at visiting, but not to take on the responsibility stuff.

Q. You make a reference in your statement to how much you think they could have got from you had they spoken to you, had you been more involved. You used phrase "lost invitations", what do you mean by that?

A. So there was at one point because obviously I'm at work,

I was working full time I think then. And I kept thinking why have we not been called to any reviews or anything? So I think I rang up and was like, "We have not had anything for ages. What's happening? It must be coming up to Val's like quarterly review or whatever, and we don't want it just to be sprung on us that she's suddenly leaving. What's happening?" It was like, "Oh yeah we sent you an invitation." I was like, "Where did you send the invitation?" Then no one seemed to know where it was or when it was. So I found one strain of things that they never actually sent that never came to me. That was when I found out I think that there was this big meeting on July 15.

Q. I was about to ask.

A. And I was like that's in two days' time. I have got to get permission to be away from work, which I did get. So it was like that. That we either wouldn't get told anything -- there were quite a lot of things that Val went to on her own and then I was like, "Why didn't we get invited to come that particular meeting?" And it was just like, "We just sort of had her there and we just sort of did it." So there were a lot of those things that happened or might be maybe one of the psychiatrists was doing a kind of a weekly round, but then a lot more would come out of that than you would expect, the

medication might change or something else, a decision might be made there and then without us getting told it because we just thought it was a weekly round or the daily round or whatever that they did.

Q. And you of course weren't involved in that?

A. No, we didn't know what was happening.

Q. Can I ask you then about that meeting on 15 July, which, as you have already told us, you say was sprung on you or you got very short notice. You call it, I think, at a number of places in your statement "Val's Annual Review". It was the Care Programme Approach meeting. Is that right?

A. Yes.

Q. And at paragraph 49, to put no finer point on it, you say that meeting had scarred you for life. Can I ask you about it?

A. It's okay, carry on.

Q. You were at that meeting.

A. I was.

Q. Was any other member of the family there?

A. No, just me and Val.

Q. And I think you describe about 15 health care professionals.

A. I think there were about 15 -- between 12 and 15 NHS people there.

Q. We have already touched upon one of the outcomes of that review meeting, I'm going to come back to the review meeting, which was this decision that Val should be assessed for a rehabilitation and recovery place, to use shorthand, at Ipswich Road, and it was, as you have already touched upon, that she wasn't accepted there because her mental state was considered to be stable, co-operative and forward-looking.

A. I mean I can't really accept that because I know 100 per cent from that meeting that she wasn't accepted there because it wasn't an option. So it isn't that there was something about her state. They just kept saying different things. So within the actual meeting --

Q. In fact, I think you say in your statement, and I am going to come on to the meeting in a moment, at paragraph 48, you say when you went to the facility, you noted the people in it were of a different age?

A. There were like 17 year olds in there. It wasn't an option and actually in the meeting Dr A was sort of murmuring about this placement, but there was one member of the team who was linked to, like where different rehabilitation-type places, and she was saying really adamantly, "It's not an option, Ipswich Road isn't an option." And I remember just thinking, "Wow they are arguing in front of me." And then a couple of other

people piped up about why it wasn't an option. Val was sitting there and they are talking about where to put her and they are arguing about this place, so it wasn't an option. I think it was just -- for me it was let's pretend we are looking at places for Val to go. Remember at the same time she was looking for a council property or another place that she could live that wasn't her own house. So she wasn't just leaving it to them. She was actively, with our help, trying to find somewhere else to live in case they just suddenly put her back out of the thing. So Ipswich Road was not an option, it was never going to be an option.

Q. Can I just ask you pick up on something you said about them arguing in front of you, in front of Val, I think you said in your statement some staff were saying she had to leave the ward, Dr A was saying he wouldn't ask her to leave the ward, others were saying she couldn't say, this discussion you have described. What effect did that discussion, did that argument as you have described it, have on Val?

A. She was just very nervous, she was shaking through most of it. She was like a little mouse. She was like a different person to the person we grew up with. She was just terrified, and all she was thinking she was just waiting for them to say the words, "You are going to have

to go home", which is when I said to the doctor, "Val is terrified. She has said if she goes home she will kill herself", and she said it there, they asked her and she said, "Yeah I will kill myself."

Q. She said it in the meeting?

A. In the meeting, "I will kill myself if I have to go home." That's when he said, "Rest assured she won't leave until she's well enough to leave." Which of course is ambiguous because who is going to say she is well enough. You only need one of those people who wanted her out to say she is well enough.

THE CHAIR: That is Dr A.

A. Dr A, and then the other doctor was not in there at that point, it was just him. I was really worried that Val might -- she was talking about getting a car at this point, and I was really worried that she was going to get a car and either have an accident because she wouldn't be able to drive because she had so many drugs in her or that she would try and cash the car again. And I asked him directly, "Is she allowed to drive", and he said, "Yes." I remember being really shocked that he would say yes. My mum really told me off, as soon as we got out she really told me off for saying it and then she said I could have written a letter. Then when we got the medical notes, that was changed that he had said no. But

he 100 per cent said yes because I was desperate, and obviously I looked it up, and I know that she wouldn't have been legally allowed to drive at that point. So that was what the meeting was, it was just going round and round in circles and at the end he absolutely assured us that she wouldn't leave until she was safe to leave.

MS HARRIS: You say in your statement, where you deal with this, about the 15 of them there. You say none of them had any sympathy. Then you say this:

"They were not joining up the dots of the care of this vulnerable elder."

What do you mean by that?

A. It was just like there were 15 different people in the room, at one point one guy said he had to go and move his car, as if that was more important than being in Val's annual review. It just felt like they were quite random people in there, but actually they had quite a lot of responsibility for her care. So I think there were some of the care in the community-type people there, but they just weren't connecting with each other. So the big picture just didn't -- it didn't seem to be a holistic approach. This person is still suicidal all this time after trying to crash her car. What are we going to do as a team to make sure that she does not kill herself?

Q. Later on in your statement at paragraph 125, when you

return to this, you say it was confusing to Val and her family as to who was actually in charge. Would that be a fair --

A. Yes, because Dr A definitely acted as if he had full control, trying to give us his assurance, but other people were shaking their heads, visibly shaking their heads, as if to say, "No you can't say that", while he was speaking it. Val was kind of reassured that would mean she could be there longer. I was, I just wanted to go straight to the CEO and say, "What is going on?" So it just felt like this is not a team that are working together, they don't have a plan and at any moment, if he wasn't there, which is kind of what happened because he went on holiday, other members are going to do what they want to do to try and get Val out at the same time.

Q. So considerable uncertainty.

A. Massive uncertainty, yes.

Q. Just something slightly different and then I am very mindful of the time, Chair. But let me just deal with this because there has to be break, as you know I think, Sofia, after no longer than 90 minutes. What you have described in some of these events and what you have referred to in your statement is you have talked about lack of sympathy, lack of compassion, lack of empathy, I think empathy is my word. As you say at the beginning of

your evidence, you have noted that some of the behaviour impacted on the dignity of the in-patients on the ward. Can I just ask you about a particular example within your statement. That's this board. There was a board, a white board or a notice board that was next to the notice board. You deal with it at paragraph 45 and you say this really struck you, I suppose these are my words but --

A. I saw it. It was in, when you walked into the ward on the left, as you walked in, there was an office and the office had a door, but it had like glass in the door, so you could see into the office. But that's where when we first, when Val was first admitted, we would go in and talk about how she was to people. And I did notice this big white board was in there, but Val was really upset about it because it had the name of patient and what they had done to try and kill themselves, the manner of suicide attempt. So it was written on there.

Q. On full display?

A. Just as you walked in the office it was there. If you looked through the window, you could see it. So work people, if they had like deliveries, you might get someone go in there. It wasn't fully private. It wasn't all private because if we went in, other people were going in as well. So Val did really complain about it, and it did, they stopped it eventually.

Q. I think you explain in your statement how Val advocated for the other patients and the lack of privacy and dignity that board revealed.

A. Yes, she would advocate for, you know, whatever if people weren't getting the right food or say some of them might have dietary needs, she would talk to them about that. She wasn't shy about going to the office and saying, "This hasn't happened, you need to look after them."

MS HARRIS: Chair, it is not quite 90 minutes but would that be a convenient moment before we move on to the October. We will take a short break now.

THE CHAIR: Ten minutes?

MS HARRIS: Ten minutes, thank you very much.

(3.21 pm)

(Break)

(3.34 pm)

MS HARRIS: Ms Dimoglou, I want to ask you about discharge planning, such as it was. You explain in your statement, and for the record this is paragraph 231, and I think this is paragraph that says "August 2014" when it should say "August 2015". Is that right?

A. All right, yes.

Q. I will just put that on the record, we identified that earlier. You explain that around August 2015 conversations increasingly focused on Val's discharge and

it was claimed, it would appear incorrectly, looking at your paragraph 232 and some of the other evidence that you refer to, that the local commissioning group were pushing for Val's discharge?

A. Yes, when you say "it appears", you mean from --

Q. As in it was claimed that is what was happening and it was an incorrect claim.

A. Val she was a bit worried about me at this point that I was getting really frustrated. She was trying to not have me go to the CEO. My brother, Pablo, the younger brother, had already, right at the very beginning of this process, written to the Minister For Health and the Care Quality Commission.

Q. And I think the CEO at the time too.

A. And the CEO. So we had already written about what we thought was a really bad approach to my mum's care, and she was always worried that things like that would mean they would be meaner to her. So I think she kind of stopped telling us things, so there was a little suggestion that she didn't like two of the members of staff, and that they were horrible to her, but she wasn't telling us the real specifics. So it wasn't again until when she was found that there was a note beside her -- am I jumping too far ahead?

Q. You are but please --

A. What did you ask me again, sorry?

Q. I was just talking about her discharge and it would appear, as you have made clear it is something you have learned since --

A. But that's the only way I found out. So no one had said anything to us there because they had basically stopped talking to us, we didn't get anything from them. So no one had said anything, we were just constantly on edge when are they going to kick her out basically.

Q. So let me take it in stages then, if I may, it is perhaps my fault. Let's do it in this way. We have already identified that one of your main concerns throughout is the lack of involvement, not only of you, but of Val herself in decision-making around her care.

A. Can I just point out that it is written into their policy, and it was at the time, that they had to involve us at every stage.

Q. Absolutely, and I think in your statement you reference some evidence that the Inquiry heard in May about that from the experts that were called. But just coming back to, you say, I think at your paragraph 234, that Val was told of what was happening. This is the way you have described it, Val was told what was happening in her care, but not meaningfully involved as far as you are concerned.

A. No, she did start talking to us about, "They are going to kick me about and now they have told the commissioners." And we were like, "Why would they do that?" So she was starting to speak like that, we thought she was worried that they were obviously saying that to her as well.

Q. I think you also point out, and we have already been through, you have given evidence about your experience when she was discharged the year before. At your paragraph 234 and 235 you say the thought of Val's discharge was "terrifying" I think is the word you use, owing to the absence of what you considered to be a clear plan for that discharge. Have I summarised that correctly?

A. Yes.

Q. You refer to the fact that you hadn't been involved, you had had very little contact with the care co-ordinator, no discharge date had been communicated and there had been no real planning involving you as far as you could see or as far as you were concerned.

A. Not for us, no that we would know of.

Q. And at paragraph 237 you say, and can I remind you of it, I hope you don't mind, you say:

"I have serious and significant concerns about the discharge decision process and communication. In 2015 it was even worse than 2014. There was no

engagement with the family by the care co-ordinator and Val's housing situation was ignored. She couldn't return to her house as it was a major trigger, yet the team resisted her move to council housing even telling her she didn't have the right to access it."

You say that:

"The council by contrast was supportive. The hospital's approach was cold and lacking in empathy and focused on moving her out without considering her needs. They said unkind and dismissive things, missing the critical fact that her home environment was traumatising her."

Then you go on to say at your paragraph 300:

"Val couldn't live with us or with herself. She needed properly a safe place away from the family to be looked after by professionals who really wanted her to stay alive. She needed to be valued for who she was, with her depression and her occasional happiness just being part of that. Val needed to be heard and believed when she said suicide was her only option if she was not allowed the stay in hospital. One day she may well have been well new to leave, but not on October 9, 2015, which any kind person could have seen."

Can I ask you about that, October 9, we know, was not in fact discharge but leave, but she was let out.

I will come back to that I promise. Can I ask you about your views as a family? As a family, what did you want or did you think could or should happen to Val to allow her to leave the ward? Because we have a situation, that you have described, where she was doing well I think in the summer months and then the conversation would move to discharge and she would become anxious and unwell again with the thought of it. As a family, what did you hope or want or think should or could happen?

A. That is a really hard question because you have got the kind of level that's like a dream, that she could come and live with one of us and it would all be really cute and nice. But you then have to think about that reality, could she have lived -- we all had quite young children at the time or children that would have found it very hard, and we were terrified if she lived with one of us she might kill herself in one of our houses because we couldn't be sure that we could look after her and be safe. We felt we couldn't look after her or give her what she needed to be safe. So you kind of have a guilt. The ideal is that that families live together and work together. Obviously, I was working really hard with her to try and find her a place to live, which again we felt we kept getting kicked in the teeth by the hospital because the woman you was supposed to be helping her do

this -- you did just say, and I want to say it more clearly, she actually said to her, and it was in the notes, that she didn't have a right to a council house because she had her own house. Again, why would you say that to someone who is suicidal? That was kind of how she was feeling that her rights were diminishing but the council were really sweet and other people were. We did have a bit of a dream that she would find a place that would work. The Alms House that my dad lives in, I wrote a really strong letter to them, begging basically, and they did offer her a place actually, which was amazing, but we were still worried if she took that, she might kill herself there where my dad was, which would not be very nice. And also the place they offered her had stairs, which she was worried about because she was quite disabled from the car accident, but also the window looked at her old house, so it was literally a few hundred feet along the road. So it wasn't ideal. But there were people who were working really hard to try and find her a place. So even after she died, someone from another housing unit, she called me actually to say, "I am really sorry". Anyway, she had, she had found a place for my mum, but like too late. Again, that might have worked because it was bang smack in the middle of town, and that might have been a big enough change for Val that

it would have been bearable. Anyway that didn't happen.

THE CHAIR: You said that the council by contrast was supportive.

A. The council were fantastic.

THE CHAIR: What do you mean by that?

A. So Colchester Borough Council, they put her on the list for council accommodation even though she had her own home because they listened to us that she couldn't live there for so many reasons. And also when they did offer her somewhere, because they did offer her some not very suitable places, but when they offered her somewhere we would go and look at it and if she said, "No", they didn't then start pressuring her to say, "You have only got like one more place and then you are off the list." They were just really patient and just kept telling us if somewhere came up and then we would go and look at it and try and weigh it up. Some of them were just, no way, but I sort of thought maybe somewhere would come up that would suit her.

MS HARRIS: What we do know, sadly, is it never got to the stage where Val was discharged and she remained an in-patient on the Henneage Ward for almost a year until 9 October 2015. You have already told us how she died at her home address, and you have already explained that she was on leave, she was on leave from the ward at the time,

but we know from your statement and for the record paragraph 215, that she wasn't escorted or accompanied on that leave or that you or any other member of your family had been told that she was going out on leave.

A. No.

Q. And the first you were aware of that leave, on 9 October, was when your sister Nicola received a telephone call from the ward because Val hadn't gone back at the allotted time.

A. Yes.

Q. I think she was due back at 9 and your sister got a call was it around 9.30-ish something of that nature?

A. It was, about 27 minutes past.

Q. Whilst you weren't aware of it at the time, I know this is something you found out later, what did you learn afterwards about how long that period of leave was for, how long was she going to be away from the ward for?

A. Well, 12 hours, she wanted to go out at 9 and come back at 9 and obviously that's October, it was getting dark, it was a bit chilly.

Q. Can I just ask sorry to interrupt how did that compare in length --

A. Never, never done it before. My brother, my elder brother, brought her to me for Christmas when she was ill from the ward, it must have been 2014. So she came for

Christmas and they wouldn't let her get back either really late or stay overnight, even though she was with us. So when she wanted to spend a Christmas in Sussex, they were really strict about what time she had to get back. But on this occasion, I know you are going to mention it but she had been on suicide watch, basically just before it.

Q. I am coming on to it.

A. Can I just go back to the housing things because otherwise I will feel I didn't say it.

Q. Yes, of course.

A. I just want to point out that my mum -- so I say she was on the council list and we were looking at houses but that isn't -- she wasn't looking at houses like "Oh yeah this is alright." She was literally shaking, when I looked at her I was just thinking it's ridiculous, how can Val be looking at housing, she can't do anything. She could not live on her own in a house. So obviously that was compounding the guilt, it didn't feel like she -- at that point I did say, "Do you want to come and live with us to try it", but then it was like, "Oh I'm not sure, I don't really want to leave everybody else because then I won't be near the other dog and everyone." So it wasn't looking for a house. It was attempting to look at places and attempting to imagine surviving in one

on her own. So we went to a few places that were sort of more communal, that she might be able to have other people around her, because that's obviously what she needed, but for one reason or another they either weren't available or weren't suitable. Sorry, back to the 12 hours. She had never been out for 12 hours and as I said even at Christmas that wasn't an option really, I think they might have let her out just for 12 hours, but with my brother. Absolutely no other time would they have allowed it. I just want to point out that the reason she gave them, that where she was going, she had given them the same reason like a day before or something. So if anyone had been -- she was obviously testing them to see how carefully they were kind of watching what she was doing. So she used to go to this sort of like a friendship group thing and she had already done it that week but she said she was doing it again and nobody ever questioned us or rang us up to say, "This is where she's going, does that sound a bit odd?" She just said, "I'm going there." And then it would not have taken 12 hours to do what she said she was doing so that could have flagged up things.

THE CHAIR: Did she ask to go on leave?

A. Well she just said "I'm going out" basically. It wasn't like you had to make an application, even so close after

being on observations. And my sister and I both used to ring her in the morning and we had both talked to her that morning, and she told us both that she was staying in the hospital all day.

MS HARRIS: Can I just take you back then to the few days before that because you just started touching on it. Again for the record it is paragraph 50 of your statement, and you have explained, we have already mentioned it as we have gone through, that on 6 October Val was seen by the ward manager. There was a meeting with the ward manager. And there are four features or four things I think we need to note about that meeting. Can I go through them with you?

A. Yes.

Q. Firstly, and you deal with this in your paragraph 50, as I say, Val updated the ward manager about her plans about trying to find accommodation and so on and so forth. That was the first things, there was a discussion about that. The second thing that happened is the ward manager, which you have discovered since, obviously you didn't know this at the time, the ward manager indicated to Val that she had invited to one of the commissioners to the CPA meeting that was fixed for 28 October as they had requested information around care plans. So she had told Val that one of the commissioners was coming to a

meeting; is that right?

A. Not about the care plan about discharge.

Q. About discharge. The third thing that we know from the notes is that on hearing that Val became visibly anxious, she explained that there were triggers for suicide that were still in her home. She expressed that at the meeting.

A. Yes.

Q. And the fourth thing we should note, which is what you have already made reference to, is that a result of this obvious anxiety and this expression of suicidal ideation, Val's observation levels were raised on 6 October from level 1 to level 2.

A. Yes.

Q. And just to underline what it was that, how they were being raised, it was agreed that there would now be checks on Val around her safety and her suicidal ideation, every 15 minutes on 6 October.

A. I can't remember the timing wise --

Q. I think it was four times an hour.

A. No, I just mean because at the same time as that, or just after that, Val had been heard speaking on the phone or pretending to speak on the phone, saying, "If they send me home I'm going to kill myself", and I think she had actually said, "I'm going to crash my car", she had said

something that was really obviously her particular way of trying to kill herself.

Q. I will come on to that, I promise. Have I got those four things from the meeting right?

A. Yes, but also the bit where the ward manager told her that the commissioner wanted to come to the meeting to see what was going on with her discharge. Val obviously knew that that was a really horrible thing to say and she got her to write it down. So she wrote it down and that was next to my mum when we found her dead.

Q. At her home address, she took it from the ward to her home address?

A. Yeah she had it in her glasses case and she had it in next to her when she died.

Q. You say at your paragraph 51, and I think you probably would say that underlines it, that we shouldn't underestimate the significance, the power of that incident and that conversation would have had on your mother; is that right?

A. Yes, totally.

Q. You consider, it's your view that that conversation was intended to scare Val into agreeing to discharge, in effect?

A. Yeah everything -- I mean, they almost had her bag packed by the door. I mean, everything, every single thing was

about her leaving. There was no communication that wasn't about her leaving.

Q. Did you later, and you explain there at your paragraph 56, you say you later learned at the inquest into Val's death that the commissioners were not considering discharging Val. They didn't have the authority in that sense, but you consider that was the impression that was being conveyed?

A. We knew that they wouldn't do that, which is when Val would talk about it, you know like offhand, we would be like "That isn't something, do you want us to look into it?" But we didn't know this person had said this to her face and then written it down to make it feel real. We didn't know that until we found the note next to her body and we also read the records where the ward manager had indicated that she had raised all this stuff again at a time when Val was really distressed. And that Val had then gone got more distressed about it but at the inquest --

Q. I was going to ask you.

A. Because I didn't have a solicitor, I did the questioning and I did ask about it directly --

Q. To the ward manager?

A. I spoke to her yes and I said, "Did you write that note because I have got it here", and she said, "Yes, I did",

and I said, "And is that true, can that happen?" And she said, "No, I should never have written that note."

Q. She says she should never have written it.

A. So she knows she should never have written the note and she did say that in the inquest.

Q. Now, that was followed by an assessment on the 7th, we will come to the telephone call in a minute, with Dr A. So the following day Val had an assessment with Dr A, and you have seen and we will come to the letter about it, that you know that at some point around the time that:

"'Ward staff reported that they ... overheard a conversation when Valerie was telling somebody about thoughts/plans to kill herself by crashing her car ..."

So you have seen that from a later report. So on the 6th she is put on to level 2s, observations, she has been viewing property without success -- sorry, this is in the records. It records that:

"She has shown reluctance to being discharged. A Commissioners meeting had been planned. Has been stable while on the ward but risk of ... suicide after discharge in the community."

This is in the records?

A. In the medical records?

Q. Yes. Paragraph 52. The records then go on to say which you set out at 52:

"Seen" -- as in she has been seen by Dr A -- "Reported frustration around finding property but she is hopeful to find one. Stated that she will be able to cope after discharge without the support she is getting on the ward. But upon questioning stated that she does feel hopeless about it to the point of contemplating suicide. Denied any thoughts of self-harm/suicide while on the ward. Discussed medications - she is not keen on any change/increase in rates due to side effects."

And the plan is written as:

"1 Reduce obs to level 1. 2. Continue with current management. 3. Carrying on looking for property ..."

At paragraph 58 of your statement you explained, and I think these are your words, that you are "perplexed and angry" when you look at these together because putting 6 and 7 October together, you consider that Val was begging not to be discharged home, as in to her home address, that she was expressing clear signs of suicidal ideation, that she was distressed and she didn't feel she could be away from the ward and that she was feeling pressure that the Trust were about to discharge her, not least because she had been there for a long time.

A. Yes.

Q. That's your take I think.

A. Yes.

Q. Your interpretation of what happened on those two days. But again you have said it and just to underline, you were not aware of any of that at that time?

A. No, nothing. We weren't aware that she had talked about suicide openly. We weren't aware that they were telling her that the commissioners were anxious for her to leave. We weren't aware of any of it and we weren't aware that she had been put on observations, even though she had never been on observations before.

Q. So you were not aware of the level 2 increase?

A. No, not in any way, nothing.

Q. And you remain concerned, you say in your statement, about the decision then to reduce them the very next day?

A. Yeah, like how could that even happen that one minute you are on 15 minute observations and then you're not -- I just want to add that both of the doctors, the psychiatrists, had been on holiday -- not together necessarily but they had been away for quite a lot of weeks. There had been a slight overlap where one of them was there, but there had been one time where there was somebody else who sort of stepped and did something to do with my mum, who she didn't really know. So it felt like kind of little bit of an empty space, there wasn't really

anyone you could ask questions of. When we did see Val she was coming outside to see us and getting us to drop her off outside. Now obviously in hindsight that was probably part of her plan to keep us away from what was going on inside. But they didn't ask to see us either. Nobody ever kind of made contact with us. And also at that time she was presenting to us as quite odd in terms of the kind of medication, and again I only found out reading the reports, that every time she saw us they were giving her diazepam.

Q. That was for leave, they were giving her diazepam. That was for leave, they were giving her diazepam. It was to help her go out.

A. Every time she came out. Yeah, they were giving her diazepam which was like "Wow". So, yeah that felt really odd.

Q. Can I ask you this, and you have mentioned and you deal with in your statement, how there really is no communication, you say, over this period of time. So when did you first learn of Val's assertion, which seems to have taken place around the 6th or 7th, that she would kill herself once off the ward? When did you first learn about that?

A. Interesting. So there was obviously an anonymous letter --

Q. I am going to come to that.

A. That's involved.

Q. After Val's death I take it?

A. There was an anonymous letter that came quite quickly after Val's death.

Q. Shall we move on to it now?

A. Well, it's just in terms of Val saying outwardly, obviously the letter indicated that but it was written in the notes, and I remember when my sister and I went through the notes, and we kept gasping "Oh my God, how did we not get told this?" So that was also there in the notes so it had been written in the notes but nobody else had told us that.

Q. So I said it was certainly after Val's death?

A. After she had died, yes.

Q. You have talked about this anonymised letter. Let's deal with that, shall we, now. It is at paragraph 64 of your statement. I think we can summarise it in this way. You became aware of a letter from a whistleblower, an anonymous letter from somebody who said they were there in and around the ward at the time, and the letter states that Val had told somebody that she was going to kill herself whilst on leave the next day, so that being the leave of the 9th?

A. Well, yes, she told someone on the phone.

Q. This is what you have at your 64. That this had been highlighted to the nurse in charge, and that thereafter the team or the clinical team, had been told to keep that quiet?

A. Yes, so the anonymous letter went, not to us but it went to the, I think it went to the CEO at the time, it went high up anyway, and then we were told about it by the Trust initially and then by the police.

Q. And I think you would say or your concern that nothing has really been done properly about it, or as a result of that letter.

A. The letter?

Q. Yes.

A. I mean the letter was just -- we were like finally someone's going to speak up, and we thought there was going to be a proper whistle blowing thing. Because it said very clearly that the ward manager told people not to get in touch with the family to tell them that Val was openly talking about suicide, which figured in to us why we hadn't been told, because we hadn't been told. So that felt like it was so real and that we thought that was it, it was all going to come out. But then we found out from the police that they did investigate the letter but they allowed the clinical manager to be in on all the interviews with the staff, which is also bonkers, and

they literally just said, "Did you send the letter?", and they said "No", or, "Do you remember them saying it?" So there was some sort of an investigation but no one was compelled to and there was the manager there.

Q. All right. Can I just move you then on to 9 October and ask you about Val's leave before that time. I think we can deal with it very quickly. At paragraph 210 you explain that she had had several instances of leave, you have touched on it already this afternoon. Most of the time she would be accompanied by one of you, one of her children; yes? Although you consider there should have been a process whereby staff would ask who she was going to be with and verify that. That is something that you have reflected on and think should be part of the leave arrangements. You are nodding.

A. Yes.

Q. That's right, isn't it?

A. Yes.

Q. And in your view now, you think that the handling of Val's leave requests overall was inconsistent and you have seen the notes, you have seen the records to this effect, I think. And you have noted that sometimes they would go so far as to include what she was wearing, and details of what she was going to do, but mostly they were blank or vague as to the arrangements.

A. Yeah, there might just be a couple of words on there.
Q. There was no involvement of the family in these leave decisions?
A. No, never.
Q. And you have already reiterated that you were not told that she had been granted leave on 9 October?
A. No.
Q. You had not been told about the increased observations on the 6th, we already know that.
A. No.
Q. And you certainly hadn't been told that it was going to be 12 hours and unaccompanied. Can I ask you this, if you had been made aware of the increased observations and the fact she had asked for 12 hours unaccompanied leave, giving the same reason as she had shortly before, what would you have done?
A. Well I think my sister would definitely have gone to the house.
Q. Your sister did you say?
A. My sister would definitely have gone to the house to see if there was a stash of tablets because we probably could imagine that was what she might be thinking. We would have absolutely said, "You have to tell us everything that she's doing." So obviously we knew, we thought she was in all day. Just as a sort of a by thing, I had had

quite a serious accident, a car accident, someone had hit my car, so I was a little bit preoccupied with dealing with trying to get another vehicle and sorting things out so I could go to Essex. So I didn't have a car either at that time and my daughter had been a bit injured in the car crash. So that was all going on and I think my mum realised I wasn't kind of as on it as usual. So she was saying enough things to the people on the ward that had they been on it they would have alerted us, and we would have just watched her every move to be honest and talked to her, you know, and tried to understand what it was, and then maybe even gone higher up in the hospital at that point to say, "All this pressure on her leaving is going to kill her", which I had already said in the July 15 meeting, I said that unequivocally, "If you send her out she will kill herself." They know this.

Q. You have since seen the leave plan or the plan for this leave request. You deal with this at paragraph 217 of your statement, you give your view on it, it is "poorly filled out". And the plan -- can I just ask you about this, in terms of safeguarding Val, if at all, while she was on leave, there appears to have been some sort of plan to telephone Val while she was out that day. Can I just ask this first of all, did she have a mobile phone, did she use her mobile telephone a lot?

A. Yes.
Q. She was happy, yes, she would use that a lot and, is that what you would speak to her on?
A. Yes, always.
Q. All right. As a plan it failed from the outset, didn't it, because the number was wrong, wasn't it, the telephone number had been written down wrong?
A. Yes, we, me and my sister saw the number and said it's not even the right number.
Q. So no-one was going to be able to get in touch --
A. They couldn't contact her anyway.
Q. So even putting that aside, I think you also say in your statement that what followed afterwards is a number of inconsistent accounts. There had been some suggestion that people tried to call her or a voicemail was left, a number of different versions, I think, about what happened.
A. Yes, there was, I mean, obviously they just seemed like lies to us, because some people said they called, some people said they didn't call. There was some sort of handover. They hadn't really talked about where she was. She wasn't back by 9 but they didn't contact us till nearly half past 9. But the main thing is why would you let someone out for 12 hours when they have never been out for 12 hours before, when they have just been on 15

minute observations?

THE CHAIR: Can I ask one thing, you say at paragraph 213:

"Val deliberately told staff false information to test whether they would check on it and they didn't."

What did you mean by that?

A. So I think the week before that she killed herself that she had been testing things, like telling them that she was going to the same place twice to see if they were going to question her. She was sort of seeing how far she could push how long she was going to be out. So she had never been to that friendship thing, she had said she was, but she hadn't. So, you know, telling them that she was going there and that she's be back by nine -- no, everything that she said could have been a little alarm bell. That's quite an odd thing. It was also an anniversary, remember, it was the anniversary of when she was admitted. It was also the anniversary of her sister's death -- her sister didn't kill herself but it was the anniversary of her sister's death -- and it was my dad's birthday. So both of the suicide attempts were kind of a bit linked to my dad weirdly, one was on his name's day, the car crash, the day after his name's day and the suicide attempt was the day before his birthday. So she had obviously -- if they'd have been thinking about anniversary as a suicide trigger, they would have

seen that that was quite a dangerous time for my mum.

THE CHAIR: Do you think she was capable at that stage of giving them a false sense of security about letting her out?

A. I mean, I find that hard to imagine that anybody would have any sense of security about letting her out anyway, so my bottom line is no, because how could they not look at her and see her as somebody really vulnerable out on her own for 12 hours and even though she said she was going to a group, it would have taken a couple of minutes just to ring me or my sister to double check where she was going to be. So I think Val was trying to do that. She was probably acting more cheery than she really was.

MS HARRIS: You have talked about Val going on leave before and there had been no prior instances of her failing to return, for example, and you have already explained to us that you had no reason to think that she was on leave at all on 9 October, because you and your sister had spoken to her in the morning and she had actually told both if you she was staying on the ward that day.

A. She didn't sound good, I mean, she didn't say she way staying in because she was having a nice time, it just felt like that was what she needed to do to stay safe.

Q. We know then that, as you say, your sister got that telephone call and as soon as she got it you both feared

the worst immediately and that your sister then went to her house and found her there with her glasses case and the note you have already described to us. Can I just ask you a little bit before we come to the end of your evidence, before we come to your recommendations or what you would like to see changed. We will come to that in a moment. But can I just ask you a little bit about what happened after your mum died. We know from your paragraph 266 that you were the one that had to call the hospital, you had to tell them that she had died, and that after that there was no outreach you say, you had no contact from the hospital at all for about a week.

A. Yes, eventually someone did ring but it took quite a long time.

Q. I am looking just momentarily at your paragraph 267, just again for the record, did you receive any support at all from the hospital or offer of support from the hospital or the Trust?

A. No, I don't think -- I don't remember any. I think my sister was probably called in to check my mum's belongings. So she would have gone into the hospital at some point to collect Val's stuff and at that point I think someone tried to say something to her but by that time we were so fed up with them.

Q. How long after do you think she went to get your mum's

stuff?

A. It probably was about a week.

Q. At that time in 2015 were you allocated a family liaison officer or anything like that?

A. I think one call where someone said something like, you know, "There are people here you can talk to", but that's all I remember.

Q. Did anyone make contact with you to offer you any sympathy or anything of that nature?

A. Again, I think that in one of the conversations there was like a, "We're sorry that it happened", but very guarded.

Q. At your paragraph 269, in fact, you make reference to particular -- just want to make sure I get it right -- you make particular individuals, I think the ward manager and the clinical manager being dismissive and defensive, in your view.

A. Yeah, I mean, I seem to remember that at one point I rang and said, "What is wrong with you all, you have done nothing, you haven't even spoken to us, you don't seem to care at all." And they were trying to say that they did. And there might have even been like a letter or something that they sent after that that was pretty insincere. I felt that they had spent the time talking to each other about how they were going to deal with this, the fact that she had committed suicide off the ward. But no,

nothing real.

Q. And you have already touched on the fact that there was a huge delay, I think you said in providing the records to you when you requested them.

A. Months, absolutely months.

Q. And that meetings were cancelled.

A. Horrific.

Q. And it's fair to say if we look at 289, you say one of the most distressing aspects was the later inquest and the behaviour of those from the Trust at the inquest.

A. Well, I mean they were openly lying about how much -- I mean they had made speeches, it was almost like they had practised a little speech about how much they liked Val. And these were the people who hadn't done the records and then they had come up with these little speeches, and then they looked really pleased with themselves that they had said it. That was quite hard, obviously. The ward manager, she didn't just say, "I shouldn't have written the letter", it took a lot of questioning to get her to that point. And then at one point when they left the inquest, we were obviously really upset, and my whole family were there, they were really laughing, we could hear them laughing in the room next door and we were like, "Wow, that's quite interesting." It felt that unpleasant, really.

Q. There was a serious incident report, there was an investigation dated 1 February 2016. I am just going to put this shortly, you say in your statement you have no faith in the conclusions of that report.

A. Well, no, the SIR report, I think it got written and we raised loads of concerns and everything to do with it was shambolic and horrible and so stressful. And then we noticed at the end that the clinical manager had had quite a lot, she had edited it and reviewed it before it came to us. So, and considering we were complaining about her, so we obviously really kicked off and then that report was investigated by an independent group called Veritas.

Q. I was going to come on to that. So Veritas were commissioned to undertake a quality assurance of it and that is dated July 2016 and it was critical of the SIR. And you deal with the sum of their findings at paragraph 278 onwards, you say that their findings included there had been:

"Unclear documentation of Val's leave plan on 9th October and inconsistent communication among staff regarding her observation level."

And:

"That NEPFT should reinforce staff adherence to the In-Patient Leave Policy, ensuring all leave plans

include thorough care planning and risk assessments."

And they also included:

"That NEPFT should improve communication protocols around changes in observation levels to avoid misinterpretation."

And:

"That NEPFT should share the coroner's findings with the care team and implement any required actions and to implement a clear version control system for investigation reports to ensure final documents are properly identified and filed."

You have already made reference to the inquest which took place in September 2016, I think; is that right?

A. Yes.

Q. And you summarised the Coroner's conclusion in your statement. This is at paragraph 145 and the conclusion was that Val took her own life while under a mental health diagnosis. That's how you have summarised it in your statement?

A. That's what they wrote on the inquest report.

Q. On the record of inquest, yes. In your statement you also refer to a much later meeting with EPUT which we spoke about right at the beginning of your evidence, which was on 13 February 2018, and you describe it in

your statement as "the most shocking meeting to date". Do you remember which one I mean? This is at 145:

"During this meeting, I was told categorically that Val was not depressed or mentally ill when she took her own life, and that staff confirmed this. This was after the coroner ruled that Val took her life while under a mental health diagnosis. At the end of the recording ... they say that Val was let out of hospital because depression comes and goes and at that time Val was not depressed."

You give your view of this at 146, and you say that you think it was an attempt by EPUT, as they then were, to cover their backs to justify how a person expressing suicidal ideation and intent on one day could then be let out on extended leave without family being notified.

A. Yeah.

Q. Have I summarised that accurately?

A. Yeah, I mean, that was to me -- I recorded that meeting. So it felt like that's it, it's all blown, they are going to be exposed for what they are because they are still lying about it now to try and cover their backs. But of course it is really hard to get anyone to take any notice or do anything about it.

Q. I would like to finish your evidence or your questions

just by looking at what you have called in your statement, your "Recommendations for change", what you would like to see happen in the future to improve the Mental Health Services and care provided. I am going to do it by reference to your statement but you tell me if I have got this right. At paragraph 304, can I summarise, you make an overall observation that more can be done to care for people both as in-patients and in the community. And you are concerned about an attitude that you say is expressed by many that you simply can't stop some people committing suicide. That's something that concerns you.

At paragraph 305, your words are:

"The drug culture of mental health care must change."

We have touched upon this and you remain of the view that Val was adversely affected by her medication regime and that there was no-one listening to your concerns and that you consider there were issues of overmedication. Can I ask about that? What is it that you would like to see? Is it clearer medication strategies, clearer communication, what is it?

A. Well, I think from the very start the doctors shouldn't just give any anti-depressants to anyone. They have got to think about what might work for that person, whether it is an anti-depressant or something else. I think

there's got to be obviously a lot more to do with alternative therapies, talking and other things. But also the whole culture of just piling on the drugs. So I, unusually I rang the toxicologist to ask to talk to them and he said to me that really and honestly older people should not be taking drugs long-term because you can't expel them, there's nowhere for them to go. And that anyone really builds up either a tolerance so they stop working or an intolerance that then does other things to you. And he said he was shocked at how many different types of drugs my mum had been given. He could identify the ones that she took to kill herself but they weren't the ones that he was talking about. He was talking about all the other ones that she was on; diazepam, back on venlafaxine. That's when I properly realised how much venlafaxine they had been giving her again, against our wishes.

Q. Your next recommendation, again, you have, I think, just already mentioned because it follows on which is you think that alternatives to drugs such as talking therapies, acupuncture, these are some examples you list, natural remedies and distracting activities as well as programmes such as voluntary work to help people feel useful and needed could save a lot of lives. You would like to see, I think, emphasis on other therapies on

non-medication therapies.

A. Yes, there's no reason why there can't be more of that because it's probably just as cost effective actually, than the massive amount people are getting charged for drugs. And in the long run you are not going to have to deal with all of these things so much. If people are actually helped not to commit suicide, and the way to help people to not commit suicide is to talk to them, the whole thing is to talk to them, to be kind, to give them purpose. So when Val was first in the ward and she was helping other people, she forgot a little bit, not altogether but she wasn't obsessing about what had happened and how she felt. She was looking after other people and helping. So there are so many ways that it could happen, it's just that society doesn't seem to want it to happen or isn't putting something in place for it to happen.

Q. At paragraph 299, just to pick up on what you said, you said:

"With real sustained talking therapy and therapeutic activities, Val could have lived to old age with dignity and some contentment."

A. Because the other thing, that I don't think we have mentioned today in that weird summer, the last summer of her life , not only were the psychiatrists on holiday,

but the psychologist had been told to end the talking therapy. So the talking therapies had just been stopped and at the same time a lot of the activities that had gone on, they also stopped. So it became a ward where people were just sort of wandering around aimlessly and there was no talking therapy.

Q. At 307 say you say:

"There needs to be no economic pressure on trusts to remove patients to their homes if they are suicidal."

Also you say you would like some explicit recognition of the need to demonstrate the same level of care and safeguarding to voluntary patients as involuntary patients.

A. Yes, so one of the things when I was doing research I came across the case of *Rabone* that went all the way to the Supreme Court. That was a young woman, same as my mum, who was a voluntary patient and they had let her out for leave without telling the parents, without question, and she had committed suicide in a public place and the parents really fought this to say they should be given the same safeguarding. When I raised this in the Inquest and other places the consensus seemed to be, "Oh no because they are voluntary patients they can just come and go." That is 100 per cent what they thought on the

ward.

Remember Val was bringing in knives and tins and all kind of dangerous things because they just treated her as someone who was coming and going and quite independent. Whether that is because the didn't want to do all the paperwork that goes with it, I am not sure. But I don't feel that she was afforded the same checks and certainly the leave plans, not just on the day that she died, but that whole week, because the whole week of leave plans were really shocking and missing some of them. That shows that she was just allowed to walk out the door.

Q. At 3.08, you say picking up on that leave plan point, this is your next one:

"Leave plans, care plans, reviews, et cetera, should be fully standardised and digital with no possibility of falsification. Failure to fill these in should be seen as a serious employment misdemeanour", those are you words.

You go on again, and you have already said this, voluntary and sectioned patients to be treated equally. Just before you answer, as a base for that, just to look at some of the previous paragraphs in your report, because at 139 you say you don't feel that staff on the ward were trained properly about the completion of

plans, including care plans, that you have noted, looking through the medical records, that there were big gaps in the leave plans, particularly on the days surrounding her death. You consider that Val was hardly involved in plans and then, of course, you go on to deal with the fact, as you already have, that you attended some meetings, but you feel there was little scope for involvement from the family. Those are some of the points you made which lead you to this, you feel, proposed recommendations about leave plans and care plans.

A. From my point of view, and obviously I'm a teacher, so we have to be very careful about duty of care as well. If we thought that a young person in our care was in any way in danger or could harm themselves or anyone else, we know we would know that we would be sacked if we didn't follow that through. There are protocols that you have to do for safeguarding that are embedded in your job, you wouldn't do the job if you were prepared the to do that. I still don't understand why these crappy little notes are allowed. I can't understand why in this day and age why it's allowed, because you can always back up or print things off if that helps to have a paper copy, but the fact that things can be changed later, anyone can add something, change it, the fact that things were missing,

there were definitely leave plans that had been taken or lost that we couldn't find. You could do something digital and the digital could record it and even better, the loved ones could see it. Why would you want to keep it secret, where people are and what's going on, if you have the permission of the patient obviously.

Q. That I think brings us on to, in fact, I am going to skip one because it brings us on to your proposed recommendation at paragraph 310, which is families should have online access to records with the agreement of the patient so they can monitor the care of the loved ones.

A. Yes, and with no pressure on them not to do that.

Q. You mean on the family?

A. No, on the patient. Especially when I was trying to stop the venlafaxine being given to her because remember she is was on it again at the end so it is very likely that it had an impact on her. So when I was trying to say, "Val doesn't really want to be on the venlafaxine and we know it is a danger to her", what I sensed and from some of the things that Val said they were also talking her saying, "No, you need to be on it." So there needs to be a culture that is not them trying to persuade the patient to do what they want them to do. There was a little clash going on there, and I think that's really strong that they are saying, "You need to be on the medication,

we know because we are the experts. Your daughter is just worried about you." There is a danger there and if we saw the records, we could see, "Oh they have given her venlafaxine again, and they haven't told us. We are going to have to sort this out." Have the conversation, maybe it's because they don't want those conversations, they are not willing to have the conversation with people.

Q. I think that probably takes us back to the one I skipped over, which is your last proposal, which is at your 309, which is that:

"Liaison at every level" -- you say -- "should happen with patients and families unless there is a safeguarding reason why this can't happen."

Because I think you say you remain extremely concerned, using the ward manager as an example, that such particular, you say, and significant information about your mother's position could be kept from you.

A. I just don't understand it. I don't understand how it can happen. I know the police in Essex did try looking into a clinical negligence case because there are so many deaths. I can't understand how in this day and age, if someone is doing their job so badly, and so dangerously, and keeping information from the families, when the policy states that they have to liaise with the family at

every level, I don't understand then how they keep their jobs or get promoted, but that is what happens.

Q. You say, and this my last question at your 292, and you say it is what still really upsets you is that, so few people really and honestly, you think, tried to help your mother even when she plucked up enough courage to ask. You say:

"It was their job to help her and they didn't. Society itself should feel ashamed of letting that happen and that no one who lacks compassion for the mentally unwell should work in that field."

A. I mean we know people work in fields they are not really suited for, it could be any job that could happen in, but this is about life and death. You know if you are doing a job and you are not really suited to it, but go kind of get through the day. But if it's someone's life in your hands and these are people who have openly said so many times, "I want to kill myself", I don't understand why everything's not about trying to keep them alive, and helping them to find a reason to stay alive and not making them feel they are a burden, so 100 per cent what was happening to Val. We knew this and we were trying to alleviate it, but 100 per cent as we saw in the records, finally, she was being made to feel that she had to leave and that her saying she would kill herself when she went

home really wasn't their concern.

MS HARRIS: Sofia, thank you, those are all the questions I want to ask. I am just going to check in a moment whether the Chair has any questions, and then there will be a short break, as you know, to see if there are any other matters arising. If there are, then we will return. But if there are not, and in case we don't return I am going to turn to the Chair to see if she has questions first.

THE CHAIR: No, I have got no further questions but I want to thank you very much for coming today and giving us your time and your thoughts.

MS HARRIS: Again, I also say thank you for coming to give your evidence to honour Val. Just in case you don't come back, can I ask now that the photographs you provided of Val be put up now.

THE WITNESS: I think that's seaweed. That's me and my brother.

MS HARRIS: You are very like her.

THE CHAIR: Thank you for sharing those.

(4.33 pm)

(Break)

HEARING MANAGER: There are no more questions for this witness so that concludes the hearing today. We will resume an Monday morning at 10 am. Thank you.

(4.41 pm)

(Adjourned until 10 o'clock on 20 October 2025)

I N D E X